Response to the State of Tennessee's Request for Information # 318.65-217 Regarding the Middle Tennessee Region of the TennCare Program

Cover Letter

December 9, 2005

Ms. Alma Chilton
Contract Coordinator
Bureau of TennCare
310 Great Circle Road
Nashville, Tennessee 37243

Dear Ms. Chilton:

The enclosed document is Coventry Health Care's response to the Bureau of TennCare's RFI, #318.65-217, regarding managed care in the Middle Tennessee Region. Coventry Health Care (Coventry) is committed to the advancement of Medicaid managed care and is excited at the opportunity to bring its proven model to the Tennessee market. Coventry's operations experience managing benefits for Temporary Assistance to Needy Families (TANF), the Aged, Blind and Disabled (ABAD) and State Children's Health Insurance Program (SCHIP) populations provides a strong foundation for application in the TennCare program.

Effective and efficient systems and organizational structure to support an end-to-end health care solution for TennCare is of paramount importance to the Bureau. As a full service carrier, Coventry brings the capabilities of a well capitalized national company and the philosophy that health care is delivered locally. Coventry currently provides services to approximately 390,000 Medicaid members in eight states through 8 health plans, three of which are accredited by NCQA and one plan is fully accredited by URAC. Here is a summary of each Coventry Medicaid plan.

HealthCare USA (HCUSA), located in St. Louis, Missouri, is a Medicaid-only health plan. HCUSA is Missouri's largest Medicaid health plan covering 42% of the Medicaid managed care eligibles in the state. HCUSA has participated in the Missouri Medicaid program since 1995 and serves approximately 164,000 members. The Missouri Medicaid managed care program covers TANF, children in state care and custody, pregnant women and SCHIP beneficiaries.

OmniCare Health Plan, located in Detroit, Michigan, began in 1979 and was acquired by Coventry in October 2004. Michigan's Medicaid managed care program enrolls TANF, ABAD and Old Age Assistance (OAA) beneficiaries. OmniCare's current enrollment of over 61,000 represents nearly a quarter of the eligible beneficiaries in its service area. OmniCare has a **Commendable** accreditation by NCQA.

Carelink Health Plans, located in Charleston, West Virginia, began in 1996 under West Virginia's Mountain Health Trust Program. West Virginia's Medicaid managed care program is limited to TANF beneficiaries. Carelink's current service area includes sixteen counties and 27,425 members.

WellPath Select, Inc., located in Morrisville, North Carolina has provided managed care services for TANF members in North Carolina's Mecklenberg County since 1999. WellPath is the only managed care organization (MCO) serving North Carolina's pilot Managed Medicaid Program and has approximately 8,400 members. WellPath covers TANF, blind and disabled, children in state care and custody and pregnant women. The initial 3-year pilot was renewed in 2002 for another term.

Health America of Pennsylvania (HAPA), located in Harrisburg, Pennsylvania, delivers behavioral health services to almost 105,000 members through Pennsylvania's HealthChoices Medicaid Managed Care Program. HealthAssurance has worked jointly with a network manager and consortium of county mental health agencies to effectively serve the needs of the population; and meet the requirements of the Pennsylvania Department of Public Welfare.

Southern Health Services, located in Richmond, Virginia, has been providing health care services to the Medicaid community in Central Virginia since 1996 under the product name of CareNet. CareNet also participates in the SCHIP and Family Access to Medical Insurance Security (FAMIS) programs in the central Virginia area. CareNet currently has over 16,200 members enrolled in the plan. Covered populations include TANF, Supplemental Security Income (SSI), ABAD and SCHIP. Southern Health Services Medicaid product has a **Commendable** accreditation by NCQA.

Coventry Health Care of Delaware (CHCD), located in Wilmington, Delaware, with an office in Baltimore, Maryland, has been providing services to Maryland Medicaid consumers since 2003 under the product name, The Diamond Plan. CHCD covers over 4,200 Medicaid members. Covered populations include TANF, ABAD, children in state care and custody and related beneficiaries.

Coventry Health Care of Iowa (CHCI), located in Des Moines, Iowa, has been providing services to Medicaid consumers since 2001. CHC of Iowa serves approximately 5,000 TANF members. CHCI's Medicaid product has a **Commendable** accreditation by NCQA.

First Health Services (FHS), was acquired by Coventry in February 2005. FHS provides a multitude of Medicaid services to 24 states. FHS is currently doing business with the State of Tennessee by providing pharmacy benefit management services. FHS manages more than $10 billion annually for state Medicaid pharmacy benefit programs. Management services available through FHS include utilization review, quality assurance, and utilization management services for medical care, long-term care, community-based care and mental health services.

Coventry has existing relationships with Medicaid managed care programs where we have demonstrated the ability to effectively interface and coordinate with the various agencies. Our *e-connectivit*y team is first-rate and has demonstrated time and again the ability to meet the needs of both commercial and public sector clients. Reporting and analysis is a strength that we have developed over the course of many years of managing both commercial and government lines of business. We are confident that the experience we have gained in our other Medicaid managed care programs coupled with our understanding of the requirements of TennCare provide a strong, stable platform on which to grow and succeed.

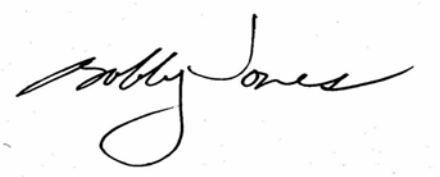
Coventry has demonstrated the flexibility to adapt to the dynamic nature of Medicaid health care needs. We are continuously seeking new opportunities to develop and improve our Disease and Case Management programs. We are able to use prospective modeling and other high-tech statistical tools and face-to-face contacts to identify patient and population needs. Coventry's Medicaid programs have been dedicated to providing exceptional member services that reflect sensitivity to members' cultural and social needs and ensure that members are able to access high quality health care services.

Coventry's medical management approach is comprehensive. From sophisticated claims processing systems, to our effective medical management protocols; and from disease management programs to our quality improvement initiatives, Coventry offers a full complement of services that manage health care effectively and efficiently, while arranging the delivery of quality health care to members.

In summary, Coventry is capable of providing a level of services well beyond those of our typical competitors. Our customer service center is state-of-the-art, and our service metrics significantly exceed industry standards. Our quality control systems allow Coventry to record calls, as well as member/provider Internet contacts and the screens accessed at the time of contact. These captured data serve as a source for our continuous quality improvement initiatives.

We have made our best efforts to ensure our response to the RFI is complete and accurate. I believe you will find that Coventry will make an excellent partner for the State given the objectives outlined in the TennCare program. We are looking forward to serving the Tennessee Medicaid population.

Sincerely,



Bobby L Jones,
Senior Vice President, Medicaid Division

Coventry Health Care Mission Statement

To be the recognized leader in providing quality, accessible, and affordable health care benefits and services that maintain and improve the quality of life of all our members and the communities we serve.

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Corporate Background and Experience Responses

Section 1: Corporate Information

Name: Coventry Health Care, Inc.
Address: 6705 Rockledge Drive, Suite 900
Bethesda, MD 20817
Telephone Number: 301-581-0600 / 1-800-843-7421
Fax Number: 301-493-0748
E-Mail Address: bljones@cvty.com
Web Site: www.cvty.com

Coventry Health Care is a publicly-traded company on the New York Stock Exchange.

Section 2: Corporate Information of Parent Organization

No response is required to this section as Coventry Health Care operates as a single legal entity with no parent company control.

Section 3: State of Incorporation

Coventry Health Care is incorporated in the State of Delaware with headquarters in Bethesda, Maryland.

Section 4: States with Current Licensure to Accept Risk

Coventry Health Care is currently licensed to accept risk in 20 states and operates 15 health plans for its various lines of business (commercial, Medicaid, and/or Medicare). The following table highlights the risk-based licensure in each state.

State	Health Plan	Type of License
Delaware	Coventry Health Care of Delaware	Health Maintenance Organization (HMO)
Georgia	Coventry Health Care of Georgia	HMO
Idaho	Altius Health Plans	Managed Care Organization (MCO)
Illinois	Group Health Plan	HMO
	PersonalCare Insurance of Illinois	HMO
Iowa	Coventry Health Care of Iowa	Iowa HMO
	Coventry Health Care of Nebraska	Non-Iowa HMO
Kansas	Coventry Health Care of Kansas	HMO
	HealthCare USA	HMO
Louisiana	Coventry Health Care of Louisiana	Insurer - HMO
Maryland	Coventry Health Care of Delaware	HMO / MCO

State	Health Plan	Type of License
Michigan	OmniCare Health Plan	HMO
Missouri	Coventry Health Care of Kansas	HMO
	Group Health Plan	HMO
	HealthCare USA	HMO
Nebraska	Coventry Health Care of Nebraska	HMO
New Jersey	Coventry Health Care of Delaware	HMO
North Carolina	WellPath Select, Inc.	HMO
Ohio	Carelink Health Plans, Inc.	Health Insuring Corporation (HIC)
	HealthAmerica Pennsylvania, Inc.	HIC
Pennsylvania	Coventry Health Care of Pennsylvania	HMO
	HealthAmerica Pennsylvania, Inc.	HMO
	HealthAssurance Pennsylvania, Inc.	Risk Assuming Preferred Provider Organization (PPO)
South Carolina	WellPath Select, Inc.	HMO
Utah	Altius Health Plans	HMO
Virginia	Southern Health Services	HMO
West Virginia	Carelink Health Plans	HMO
Wyoming	Altius Health Plans	HMO

In 2005, Coventry Health Care purchased First Health Services (FHS). FHS provides pharmacy benefit services, fiscal services, and authorization services in 24 states and the District of Columbia.

Section 5: Contact Information

Inquiries regarding this RFI or Coventry's Medicaid health plans may be directed to:

Name: Mr. Bobby L. Jones
Title: Senior Vice President, Medicaid Division
Address: Coventry Health Care, Inc.
1333 Gratiot Avenue, Suite 400
Detroit, Michigan 48207
Telephone Number: 313-465-1518
Fax Number: 313-465-1605
E-Mail Address: bljones@cvty.com

Section 6: Program Experience - General

Coventry Health Care, a Bethesda, Maryland-based organization, provides a full range of managed care products and services, including commercial and Medicaid HMO plans, commercial PPO plans, commercial POS options, Medicare Advantage, and ASO Network Rental to approximately 2.5 million members.

Coventry Health Care, Incorporated and its subsidiaries are well capitalized. In 2004, the company generated over $5.3 billion in revenue. According to the November 29, 2005 A.M. Best Ratings Supplement press release, Coventry's financial strength ratings are either B+ or B++ (very good) for all of its subsidiaries and all have stable outlooks. Coventry's issuer credit and debt ratings also have stable outlooks. Coventry is a ***Fortune 500*** company that has received national recognition. For example, Coventry received the following performance acknowledgements:

Rated 10th Best Performer by the Wall Street Journal
Rated one of The Best Big Companies by Forbes
Ranked #1 Overall by Barron's

Coventry is an experienced Medicaid contractor, currently managing benefits for approximately 390,000 Medicaid enrollees in eight states: Iowa, Maryland, Michigan, Missouri, North Carolina, Pennsylvania, Virginia and West Virginia. All agreements are traditional MCO contracts except in Pennsylvania, which is for a managed behavioral health management program. The majority of our Medicaid MCOs have held managed care contracts for over three years. Our recently acquired Michigan health plan has pioneered Medicaid managed care programs for nearly thirty years.

This extensive Medicaid experience has resulted in an in-depth understanding of the challenges and opportunities in servicing this population, an understanding of the respective regulations of state governments and a knowledge, respect and dedication to the special needs of the state and Medicaid consumer. Coventry is well positioned to bring an experienced management team, enhanced case management capabilities, strong outreach programs, community engagement philosophy, effective Information Systems programming and financial stability to the management of the TennCare program.

A. Capitation Experience

Coventry has over three years of Medicaid MCO experience in six states, which is summarized in the following chart:

State	Health Plan	Contract Period
Iowa	Coventry Health Care of Iowa	7/1/03 through 6/30/06
Michigan	OmniCare	10/1/04 through 9/30/06 with three one-year renewal options
Missouri	HealthCare USA	Eastern MO & Central MO Regions: original term 1/1/03 through 12/31/03 with one-year renewals until next RFP Western MO Region: original term 1/1/04 through 12/31/04 with one-year renewals until next RFP
North Carolina	WellPath	10/1 of each year - annual renewal based on acceptance of the rates
Virginia	CareNet	7/1 of each year - annual renewal based on acceptance of the rates
West Virginia	Carelink	7/1 of each year - annual renewal based on acceptance of the rates

In addition, Coventry has operated a Medicaid health plan in Maryland since 2003.

B. NCQA Accreditation and HEDIS / CAHPS Experience

Coventry is committed to the support and advancement of health plan accreditation as a demonstration of a plan's capacity to deliver high quality health care services. Many of our health plans are NCQA and/or URAC accredited. Our Michigan health plan has been NQCA accredited since the early 1990's. Two of Coventry's health plans were recognized by NCQA as *Outstanding* in the October 2005 U.S. News and World Report magazine.

Coventry has considerable experience with leading accrediting entities and several of our employees have served or currently serve as NCQA reviewers. We endorse the Bureau of TennCare's position regarding health plan accreditation and are willing to have a Tennessee-based health plan accredited by NCQA given a reasonable period following contract award.

Coventry health plans have extensive experience with Consumer Assessment of Health Plans Survey (CAHPS) and Health Plan Employer Data and Information Set (HEDIS) reporting. Results from these key quality indicators are used to gauge plan performance and enhance Quality Improvement programs. Recently, 2005 HEDIS reports were generated for seven of eight Coventry Medicaid plans. CAHPS surveys were generated for all plans during the same period. Our sophisticated IS technology enables us to accurately collect, collate and assess HEDIS and CAHPS data.

Coventry Health Plan Accreditation Summary

		Accreditation		
		NCQA		URAC
Health Plan	**State**	**Commercial**	**Medicaid**	**Type**
Carelink*	West Virginia			HP
CHC-Georgia	Georgia	Y		UM
CHC-Iowa*	Iowa	Y	Y	
HAPA*	Pennsylvania	Y		
CHC-Kansas	Kansas			UM
CHC-Louisiana	Louisiana			UM
CHC-Nebraska	Nebraska			UM
Southern Health Services (CareNet)*	Virginia	Y	Y	
Group Health Plan	Missouri			HP
HCUSA*	Missouri			Filing an application
CHC-Delaware*	Maryland			HP
WellPath*	North Carolina			UM
Personal Care	Illinois	Y		
Altius	Utah			UM
OmniCare*	Michigan		Y	

* Denotes those plans with Medicaid contracts; UM denotes Utilization Management accreditation; HP denotes Health Plan accreditation

C. Current Contracting Status for Medicaid

Coventry has considerable experience delivering high quality health care services under Medicaid risk-based contracts in eight states across the country. These Medicaid contracts

include various populations such as Temporary Assistance to Needy Families (TANF), Aged, Blind, and Disabled (ABAD), State Children's Health Insurance Program (SCHIP), Old Age Assistance (OAA), children in state care, and pregnant women.

Section 7: Medicaid Program Experience - Services

The following chart lists covered benefits by health plan. Categories with "Y" mean the benefit is covered in the plan contract. All Coventry Medicaid plans cover physical health and related services, with the exception of Coventry's Pennsylvania plan. This plan provides behavioral health coverage only. Use of subcontractors is denoted by name of subcontractor.

BENEFITS COVERED	COVENTRY MEDICAID HEALTH PLAN STATES							
	NC	WV	VA	IA	MD	PA	MO	MI
a. Physical Health Benefits	Y	Y	Y	Y	Y	N	Y	Y
b. Dental Benefits	N	Y Limited benefit	N	N	Y Doral Dental	N	Y Doral Dental	N
c. Vision Benefits	Y Avesis	Y	Y Allied Eye	Y	Y Block Vision	N	Y	Y Heritage Optical
d. Non-Emergency Transportation	N	N	Y Local Motion	N	Y	N	Y	Y MTM
e. Behavioral Health Benefits	N	N	Y Sentara Behavioral Health Services	N	Y United Behavioral Health	Y CBHNP	Y MHNet	Y Value Options (Limited benefit)
f. Pharmacy Benefits	N	N	Y Caremark	N	Y Caremark	N	Y Caremark	Y Caremark (partial carve-out)
g. Long-Term Care Benefits (nursing facility and home and community based waiver services)	N	N	N	N	N	N	N	N
h. Home Health	Y EHS	Y	Y	Y	Y	N	Y	Y
i. Claims Processing and Adjudication	Y EHS	Y	Y	Y	Y	Y	Y	Y
j. Quality Assurance	Y EHS	Y	Y	Y	Y	Y	Y	Y
k. Utilization Management	Y EHS	Y	Y	Y	Y	Y	Y	Y
l. Case Management	Y EHS	Y	Y	Y	Y	Y	Y	Y

BENEFITS COVERED	COVENTRY MEDICAID HEALTH PLAN STATES							
	NC	WV	VA	IA	MD	PA	MO	MI
m. Disease Management	Y EHS	Y	Y	Y	Y	Y	Y	Y
n. Provider Credentialing	Y EHS	Y	Y	Y	Y	Y	Y	Y
o. Enrollment Assistance *	Y	Y	Y	Y	Y	Y	Y	Y
p. Member Services (inquiry, id cards)	Y EHS	Y	Y	Y	Y	Y	Y	Y
q. Member Grievance /Appeals	Y EHS	Y	Y	Y	Y	Y	Y	Y

* Each Coventry Medicaid health plan works with its respective state enrollment brokers or Medicaid agencies to complete the member enrollment process

Section 8: Medicaid Program Experience - Population

COVENTRY MEDICAID HEALTH PLAN STATE	ENROLLMENT BY SPECIFIC COVERAGE CATEGORY (AS OF 9/05)							
	ABAD	DUAL ELIGIBLE*	TANF/ TANF RELATED	SCHIP	WAIVER EXPANSION POPULATIONS	SPMI*	SED*	PLAN ENROLLMENT TOTAL
IA			5,043					5,043
MD	656		3,602					4,258
MI	10,831		51,064					61,895
MO			145,729	18,196				163,925
NC	438		7,991					8,429
PA	8,394		93,275	3,253				104,922
VA	1,933		13,318	991				16,242
WV			27,425					27,425

* Enrollees in these eligibility categories are included in the applicable broader category defined by states.

Section 9: Medicaid Program Experience - Payment Methods

For the purpose of this RFI response, full-risk shall be defined as receiving a monthly capitation payment based on the age/sex of the enrolled member to cover all contracted benefits/services. Seven of our eight health plans provide the full spectrum of Medicaid medical care. Our

Pennsylvania plan is only contracted to provide managed behavioral health services. Coventry Medicaid health plans enroll TANF, ABAD, OAA, dual eligibles, SCHIP, pregnant women, and other populations under risk-based contracts. The following chart summarizes the Coventry Medicaid contracts by state:

State	Payment Methodology	Other
Iowa	Full Risk	
Michigan	Full Risk (Selected HIV medications and psychotropics are carved out.)	Quality Incentive Withholdt
Missouri	Full Risk	
North Carolina	Full Risk	MLR min-85%
Maryland	Full Risk	Incentive/ Disincentive system
Pennsylvania	Full Risk	
Virginia	Full Risk	
West Virginia	Full Risk	

Maryland and Michigan are the only states where we currently contract that include quality of care incentive payments. Michigan's payment is based on each participating health plan's ability to exceed the national Medicaid 50th, 75th or 90% percentile (benchmarks) of designated HEDIS measures. Also included in the incentive payment calculations are the plan's accreditation status, data reporting, care access levels, and its CAHPS survey results. The following is an excerpt from the State's incentive program.

Clinical Measures - 2004 HEDIS	**2004 HEDIS Score**	**50% (1 point); 75% (2 points); 90% (4 points)**	**Median**	**75%**	**90%**
Immunizations					
Childhood - Combo 1	70.1%	2	59.6%	68.4%	73.7%
Childhood - Combo 2	65.0%	2	55.6%	63.1%	69.4%

Points are totaled and payments are made to the plans based on points and membership.

The State of Michigan funds the program by creating a pool via a deduction of .0015% from each health plan's monthly capitation payment. After the year-end measures are finalized, the pool is distributed to the health plans based on the number of measures that have been met or exceeded. Coventry's Michigan plan has received an incentive payment since inception of the program.

The State of Maryland has a Value-Based Incentive program. This program rewards performance based on its defined quality and operational metrics. In addition, this program includes disincentives for performance below the state's benchmarks. The Coventry plan licensed in the state is an active participant in this program effective contract year 2005.

The State of North Carolina has a contractual requirement for the cost of care. The minimum is 85%. If the medical loss ratio (MLR) falls below 85%, the difference has to be returned to the State. If the actual cost exceeds 85%, the health plan is at risk for the excess. The intent of this approach is to ensure at least 85% of the capitation payments paid to the health plan are utilized for direct medical care and associated costs.

Section 10: Experience - Former Medicaid and/or Commercial

No response is required to this Section, as Coventry currently maintains active Medicaid contracts in eight states.

Section 11: Reformed Managed Care Model

Coventry is experienced in managing comprehensive managed care delivery systems in capitated environments. Health care interventions commence at enrollment and continue throughout the full continuum of care to positively impact the health status of covered populations. Interventions range from population-based wellness and preventive activities to intensive complex case and disease management of high-risk members and catastrophic cases. In partnership with Behavioral Health Organizations (BHOs), Coventry manages a broad spectrum of physical and mental health services.

A. Behavioral Health

Coventry and its associated BHOs have extensive experience in managing the care of members as they move between the physical and behavioral health systems.

1. Services Provided

As Coventry has relationships with several BHOs, we are fully capable of accepting a broad range of risk (capitation) for behavioral health services.

Most Coventry/BHO subcontracts delegate claims payment and network development/ maintenance. There is strict oversight and monitoring from the health plan in accordance with NCQA and URAC standards. Member appeals are managed in accordance with accreditation standards, Medicaid contract and applicable licensure statutes.

For example, Coventry Michigan receives capitation to cover 20 outpatient visits per year. The health plan's BHO is Value Options. The health plan is not at risk for inpatient, chronic mental health conditions or substance abuse services. In addition, the State assumes responsibility for the behavioral health services for the SED and SPMI populations. The health plan also partners with Caremark Pharmaceutical Services as a Pharmacy Benefit Manager (PBM) to manage and assure 40% risk for the utilization of behavioral health medications, e.g., antidepressants.

Coventry Missouri takes full risk for the entire spectrum of physical, behavioral and pharmaceutical services provided to its members. This includes all outpatient and inpatient care, including detoxification services. The health plan contracts with and sub-capitates MHNet, a BHO, to manage all behavioral health services within the Missouri Medicaid managed care program's basic mental health benefit package. For the SED and SPMI populations, any behavioral health services that are not part of the basic mental health benefit package are not managed through the health plan due to the state's arrangement with a care management organization for more complex services. The health plan provides strict oversight of the BHO to assure the very highest standards in the areas of member/provider services, appeals, claims and credentialing.

Coventry Maryland is capitated for physical and behavioral health services, which includes pharmacy. Behavioral health services are coordinated through United Behavioral Health, the health plan's contracted BHO. Coventry Virginia is capitated for physical, pharmacy and behavioral health services. Coventry's West Virginia, Iowa and North Carolina health plans are only capitated for physical health services.

Coventry Pennsylvania (PA), through its CBHNP, provides a comprehensive array of services such as mental health inpatient/outpatient care; case management; crisis intervention; drug and alcohol treatment (inpatient/outpatient settings and therapies); special programs for children including non-hospital residential treatment facilities, mobile therapy, therapeutic support services (wrap-around); and programs unique to adults, children, aging; SED and SPMI populations.

Coventry PA contracts with a CBHNP, on a per member per month capitation reimbursement system, to manage care. The CBHNP in turn subcontracts with Medicaid licensed providers (community mental health centers, hospitals, residential facilities, specialized programs, individual in private practices, etc) to provide the actual services. The CBHNP further authorizes services and pays claims on a fee-for-service basis according to an established rate agreement.

Coordination across entities is accomplished through a comprehensive reporting process that includes detailed accounting of authorizations, encounters, and claims paid. The behavioral health entity maintains detailed medical histories for members that include primary care physician (PCP), medications, hospitalizations, etc. Any time a diagnosis, treatment, or outcome has implications for the member's medical condition, the medical provider and/or MCO is informed.

Coordination of care is one of the most important components of Coventry's partnerships with BHOs. Coventry and BHO case managers maintain regular contact through various programs and communication channels, to ensure member access to integrated care. For example, BHO and Coventry case managers collaborate regarding disease management (DM) programs. They work together to identify members with a history of behavioral health issues and/or who are at risk for certain medical conditions. The Coventry and BHO case managers also collaborate to ensure the most appropriate providers are available for the member. The monitoring and tracking of a member's behavioral health progress based on the member's individualized treatment plan is shared regularly between the Coventry and BHO case managers. The member's PCP is kept abreast of behavioral health developments via the BHO case manager's daily treatment reports.

2. Medical Management Model

Coventry's medical management model is based on personalized care, strong prior-authorization concepts, and constant service coordination with all care delivery partners. The initiation of each member's care begins with an assessment of individual needs. Coventry members are evaluated using Health Risk Assessment tools (HRAs) post enrollment. Embedded in this HRA is a behavioral health component. The HRA is utilized as an important coordination tool for communication of member needs between Coventry behavioral health and primary care providers.

Important services such as imaging and outpatient services go through a prior-authorization process. The prior-authorization process allows Coventry medical

management staff to serve as a conduit for the coordination of behavioral health and medical services. Care coordination with PCPs on behavioral health services for their patients is completed during prior-authorization, case management and concurrent review processes. For example, inpatient stays undergo daily case review, with all catastrophic cases being assigned to a complex case manager for ongoing care coordination. Complex case managers are able to ascertain the need for post-stay behavioral health services. In addition, members with common but serious diseases such as asthma, diabetes or heart disease are matriculated into DM programs. Components of these programs include assessments for depression and other common behavioral conditions that may be associated with such chronic diseases.

Care coordination expectations are clearly communicated within the tenets of each behavioral health agreement executed by Coventry's Medicaid health plans. Coventry's Medicaid health plans and their partner BHOs have developed programs that effectively serve Medicaid populations. Coventry, in compliance with NCQA and URAC standards, provides stringent oversight of contracted BHOs to ensure coordination, access, and quality.

BHO providers for all Coventry Medicaid markets comply with each unique health plan's established rules for coordination. Mutual success on the part of the health plans and their BHOs is strongly tied to a healthy care coordination philosophy. For instance, Coventry Pennsylvania's contracted BHO has an established care coordination process to ensure total patient care. Some of the tenets of this process include:

- Regular meetings with providers, community agencies, advocacy groups, and consumer organizations to inform on medical and behavioral health benefits/services.
- Development and implementation of policies and procedures to facilitate care coordination with providers, counties, and the MCO; in accordance with state and federal confidentiality requirements.
- Managing health care costs and improving access to care, particularly for children in out-of-home placement, dually diagnosed persons (MH/D&A and MH/MR), the hearing impaired, persons with HIV/AIDS, the criminal justice population, the elderly, and medically fragile persons. The BHO's provider training and education programs are designed to encourage PCPs to help them achieve these goals.
- Coordination with all member caregivers to ensure medical needs are met while addressing behavioral health issues.
- Utilization of established strategies for delivering clinical services and case management to special needs populations, such as individuals with dual diagnoses and or serious medical conditions (including brittle diabetes, multiple sclerosis, life-threatening cancer, Parkinson's disorder, serious brain trauma, Huntington's Chorea, etc.)

Coventry Medicaid plans serve ethnically diverse populations. Several key functions are employed to ensure no barriers exist limiting a member's access to care, based on their ethnic or cultural background. Each market demonstrates a different mix of membership, with a prevalence of Spanish-speaking members found in most Coventry health plans. Coventry health plans are able to identify primary languages spoken by most members, which gives vital insight into the potential cultural and linguistic needs of covered populations. This information is used to ensure provider and Coventry

workforce recruitment encapsulates the diverse needs of every Coventry member. All Coventry subcontractors, including behavioral health entities, are contractually required to support our diverse membership base via their ethnically diverse staff and partnerships with key community cultural groups. Coventry and its providers make available the use of translation services, to support non-English speaking and hearing/vision impaired members.

3. SED and SPMI Populations

a. Experience – In general, coverage of SED and SPMI services are carved-out of Coventry's full-risk Medicaid managed care contracts or are limited in nature. For example, with Coventry Missouri, only basic mental health benefits are covered for the SED and SPMI populations through the health plan. Additional mental health services are covered either through the special Care Management Organization (CMO) that is contracted with the State of Missouri for children with severe mental health needs or through the Department of Mental Health's Community Psychiatric Rehabilitation program.

Coventry however, does have experience in the total management of SED and SPMI populations through its Pennsylvania Medicaid program. The Pennsylvania (PA) contract is specifically for the delivery of behavioral health services to the fee-for-service (FFS) population and any MCO carve-outs. Services are not provided through the traditional MCO arrangement. In PA, Medicaid eligibles diagnosed as SED/SPMI are included among our priority populations, specifically defined as ***"the unserved, underserved and special populations, particularly addressing persons with serious mental illness; children and adolescents with serious emotional disturbances; substance abusing adolescents; persons with addictive diseases, including pregnant substance abusers and IV drug users."*** CBHNP on behalf of Coventry Pennsylvania, employs various strategies for an all-inclusive approach to care for these populations.

Strategies for Service

Delivering clinical services to priority populations requires creative, resourceful planning and coordination to ensure appropriate use of limited resources and prevent duplication of necessary services. The CBHNP has developed the following strategies for the delivery of services to priority populations.

<u>Resource Prioritization</u>

Services are prioritized to those most in need: children and adolescents with serious emotional disturbances (SED), adults with serious mental illness (SMI), substance abusing children and adolescents, dually diagnosed persons, and individuals with psychiatric and addictive disease emergencies. Underserved populations, such as dually diagnosed persons, pregnant women using alcohol or other drugs, substance abusing adolescents, IV drug users, persons with HIV/AIDS, the elderly, and juvenile and adult criminal justice populations present some of the greatest challenges. In partnership with network providers, the BHO ensures its panel can support the member capacity and treatment/education/prevention requirements of all enrollees.

<u>Coordination of Services</u>

Communication among behavioral health providers, members, and other care providers is paramount for effective care, especially for persons with co-existing physical impairments and/or diseases. Because multiple treatment providers are

often involved with such individuals, shared communication requires a designated Clinical Care Manager to coordinate an individual's care. CBHNP will be accountable for facilitating this assignment and will monitor appropriate performance based on best standards of practice.

Coordination of care for SED children and adolescents requires a special focus. Many children with a serious emotional disturbance and/or an addictive disease are involved with multiple service agencies. Many children with addictive diseases are often identified while in mental health treatment. It is a challenge for the families of these children and adolescents to agree to drug and alcohol treatment. Coordination of care with mental retardation, school districts, child welfare services, and juvenile justice services is critical.

Community Integration

Members should receive services in appropriate community-based programs and in the least restrictive environment available. Because the Medicaid program involves multiple community service organizations, program development will incorporate community leaders, community support agencies, provider systems, members and family members. CBHNP has experience working closely with community leaders to problem-solve and coordinate outreach to underserved populations. CBHNP understands that there are many reasons people do not access care and has formed partnerships with local stakeholders to try to provide outreach and support to the people that they work with.

Whole Person Focus

CBHNPs Clinical Care Managers strive to address all member needs, using a holistic approach to treatment, assuring that behavioral health needs are addressed within the context of the person's lifestyle. The CBHNP staff can assist in ensuring a thorough evaluation and assessment of medical issues and facilitate communication between medical and psychological health providers in the member's service area.

Outcome Focus

Treatment should be guided by defined outcomes, measurable goals, and research-supported best practice approaches to treatment. CBHNP has standards of care and monitors those standards, providing research and training on outcomes-proven treatment technologies for major categories of disorders. Surveys include a focused assessment of how well treatment addresses the needs of priority and special needs populations.

Emphasis of Recovery and Resiliency Models

Use of Resiliency and Recovery Models for behavioral health services with these common characteristics is employed by CBHNP:

• Consumer-centered • Empower clients • Racially and culturally appropriate • Are flexible • Focus on strengths	• Normalize and incorporate natural supports • Meet special needs • Are accountable • Are coordinated

Strategies for Special Needs Population
CBHNP recognizes the need for specific strategies for delivering clinical services to the special subgroups among the SED and SPMI populations. The previously described processes are the basis for care management of the following special conditions, and are expanded to include other care protocols (as dictated by the disorder):

- Co-occurring Psychiatric and Addictive Disorders
- Autism and Severe Disability
- Childhood/Adolescent Mental Retardation and Behavioral Health Disorders
- Adult Mental Retardation and Psychiatric or Addictive Disorders
- Adolescent Addictive Disorders
- Elderly Behavioral Health Needs
- Homeless Populations

b. Design Choices – Coventry is open to all options regarding the care of the SED and SPMI populations. An effective structural design recommended is the use of health plan contracted panels, with community mental health boards/providers encouraged to participate in these networks. State developed rates for inclusion of these services should be based on actuarially sound rates for this level of specialty care.

c. and d. - Coventry is not opposed to any modifications proposed by the State of Tennessee. Coventry's previous experiences indicate flexibility in working with several variations of behavioral health programs. As a result, our interest in bidding would not be impacted, positively or negatively, should the TennCare program exclude these benefits or implement them via a no-risk program. However, our experiences suggest that the most effective programs in managing and coordinating care include these benefits as part of the managed care program to be implemented.

4. Essential Community Provider Experience
Coventry Medicaid plans and their associated BHOs establish contracts with Essential Community Providers. Inclusion of these key providers in proposed networks is a significant factor in our BHO contract selection process. Care delivered via the local community mental health system is critical in the effective delivery of behavioral health services to the Medicaid population. In one example, Coventry's Michigan Medicaid plan is contracted with Value Options (VO) for the administration of its outpatient behavioral health benefit. VO in turn includes providers from the Wayne County Community Mental Health Board in its credentialed panel. The Wayne County Community Mental Health Board and its providers are considered essential provider's in the administration of behavioral health benefits to underserved areas. Moreover, both the health plan and VO serve on the CMHSB's community advisory board, which facilitates greater integration of services. Similar relationships exist in other Coventry Medicaid markets.

5. Proposal Design
The most successful behavioral health models are not fragmented in capitation or responsibility. The recommended program should include behavioral health services as part of the MCOs responsibilities. Services can be effectively coordinated with no duplication, thereby creating savings for the TennCare's. The program should include outpatient, inpatient, substance abuse and rehabilitation services. Funding should be computed using an actuarially sound rating methodology. Contracts between the health

plans and the BHOs may be executed under capitated or fee-for-service arrangements depending upon the preferences of the two parties.

B. Pharmacy Services

Coventry has a very solid pharmacy department fully experienced in all facets of providing the pharmacy benefit. The Pharmacy Department is headed by a licensed registered pharmacist, with oversight by the Pharmacy and Therapeutics Committee (PTC). The PTC is responsible for evaluating all new medications, generic utilization, fraud and abuse, and maintenance of the formulary. In addition, this department is responsible for negotiating all rebates with pharmaceutical manufacturers.

1. Pharmacy Carve-Out Approach

Coventry takes an active role in managing pharmacy benefits with all contracted PBMs. In partnership with its BHOs and PBMs, Coventry has a comprehensive program for physician education, formulary compliance, drug utilization interventions, generic substitutions, narcotic over-utilization and drug interactions due to poly-pharmacy.

Coventry employs as its standard cost containment strategy the utilization of local formulary design with regional oversight. At the local level, health plans work closely with state Medicaid agencies to ensure that formularies are developed that include required coverage categories, utilizing the most cost effective product in class. In doing so, the local health management staff establishes a stringent prior-authorization program and coordinates with its PBM for implementation. The PBM and health plan monitor the established prior-auth program for modifications based on drug efficacy, new product introduction, and achievement of cost goals. Coventry has a strong pharmacy department experienced in formulary development and management. In addition, best practices guidelines and disease management approaches for depression, schizophrenia, bipolar and ADHD conditions are established. Fraud identification protocols to reduce medication fraud are established as well.

2. "Real-time" Information Requirements

In a carve-out scenario, Coventry is accustomed to receiving "real-time" claim information and data, prior-authorizations, and quantity limits. The same information should be available in the Tennessee market to support any proposed carve-outs. In addition, information about the prescribing physicians is necessary to track prescribing patterns for quality and fraud and abuse monitoring.

Under a pharmacy carve-out, Coventry health plans need the pharmacy data and related information to complement their outreach and quality of care programs. It is necessary to share the information with the PCP for inclusion in the member's medical chart. In addition, the data becomes a source for identification of members suffering from certain illnesses.

C. Long-Term Care Services

1. Coordination with Acute Care

High-risk individuals benefit from Coventry's complex case management programs. Members are tiered based on low, moderate and high needs. Needs are assessed based on complexity and severity of an individuals health care status. Individuals with

special needs related to behavioral health, mental retardation and related conditions are identified prior to placement in Medicaid-certified nursing facilities through the Pre Admission Screening and Resident Review (PASRR) program.

The complex case management programs offers significant flexibility to nurse managers for administration of hard and soft benefits. The services provided are determined based on the member's condition, benefits, place of confinement and social needs.

Under most Coventry Medicaid contracts, beneficiaries in nursing homes are ineligible for managed care enrollment. Some Coventry Medicaid contracts call for the provision of limited acute care. In these instances, we arrange for comprehensive services including physician home visits.

To identify and manage members potentially eligible for long-term care, Coventry's medical staff utilizes internal tools. Individuals entering long-term care are evaluated for level of care as well as with the Minimum Data Set (MDS) tool and Resource Utilization Groups (RUG) classification. These tools can be used as methods for identification of need and stratification of medical risk. Authorizations for hard and/or soft benefits are then provided based on the evaluation completed by the complex case manager.

Complex case managers are accustomed to coordinating services with multiple agencies to reduce service duplication. As a result, the case manager is responsible for understanding benefit packages and coordinating care with appropriate agencies. By utilizing multidisciplinary approaches, Coventry is able to ensure efficient use of resources.

2. Recommended Incentives Regarding Alternative Care

A community choice program could be considered within an MCO's care management program at the time of the level of care evaluation. The health plan would provide beneficiaries and family members with information on community services and options available in lieu of institutional care. Such a program could be part of the certification or part of a utilization management program. Goals for a community-based alternative initiative could be measured in admission to nursing home per thousand recipients compared to previous history. Deferred inpatient days will also be included as part of program evaluation. Recipient and family satisfaction could also be measured through surveys as part of a comprehensive quality assurance program. Coventry is prepared to work with the State to develop an annualized incentive program to reward health plans for increasing home- and community-based service utilization.

D. EPSDT Incentives

The receipt of necessary childhood preventive care, including early and periodic health screenings, is the foundation for building healthy adults. Many childhood, adolescent, and adult diseases and disorders can be prevented or minimized if detected early. Coventry Medicaid health plans offer EPSDT programs designed to promote the receipt of recommended health services for beneficiaries under age 21. The key components of Coventry's EPSDT program are: (1) access to services; (2) member/provider education; (3) outreach; and (4) internal tracking/monitoring systems.

Access to Services

Delivery of most EPSDT services are provided via health plan PCPs. The PCP is the cornerstone of our health care delivery system. In some states, the Medicaid managed care contract allows beneficiaries to seek some EPSDT services (primarily immunizations) via local health departments. Under these circumstances, a well structured state immunization registry is critical for health plans and other providers to ensure improved coordination of these specific EPSDT services for health plan members.

Member and Provider Education

Coventry education programs utilize written and oral communication designed to effectively inform all EPSDT eligible individuals (or their families) about the program. This information is available for the hearing and visually impaired, and in predominant languages. Coventry uses clear and non-technical language and provides information about the following:

- Benefits of preventive health care
- Available services, which are of no cost to eligible individuals under 21 years of age, and where and how to obtain those services
- Availability of transportation and appointment scheduling assistance

Coventry's approach to promoting compliance with EPSDT services through education includes the following:

- Written and Telephone Reminders to Members and Providers
    - Written reminders are sent to members and providers prior to the EPSDT screening due date. If no claim for EPSDT screening is documented, reminder letters are sent at 30 and 60 day intervals
    - Birthday card and back to school reminders are sent to families regarding childhood and adolescent immunizations and well care visits
    - Beginning in 2005, lead screening reminders were sent to members and PCPs
- Education materials describing the Coventry EPSDT program are included in all new member enrollment packets, handbooks, member newsletters, and the member Web site
- Coventry health plans also partner with community stakeholders to promote EPSDT education, including school districts, WIC programs, local health departments and Head Start agencies
- Coventry provider orientations feature a description of the Coventry EPSDT program outlining the health plan's and PCP's roles in providing outreach and education to members. It also includes information about proper EPSDT documentation and billing procedures

Tracking and Monitoring Systems

Coventry EPSDT include use of established tracking systems which provide current EPSDT status reports. Two internal Coventry information systems are used to track EPSDT program compliance. One is a claims-based internal data system which has the capacity to produce Centers for Medicare and Medicaid Services (CMS) 416 look-alike reports. The second one is a web-based internal data system that extracts data from the Coventry data warehouse. This allows us to generate reminders to members and providers. T he Coventry EPSDT program also includes periodic chart audits to monitor the completeness of EPSDT exams and validate billing procedure codes.

Incentives

Physician Incentive Programs:

Physician incentives are included in provider contracts for several Coventry Medicaid plans. For instance, providers contracted with Coventry's Michigan health plan are encouraged to support high levels of EPSDT screening for some core preventive services, such as immunizations, to support the plan's goal of exceeding NCQA national benchmarks. The Michigan plan utilizes a "bill above" strategy to increase delivery of preventive services. The "bill above" strategy allows providers to receive a payment above normal Medicaid FFS reimbursement when certain preventive services are billed, such as EPSDT screens.

Some Coventry EPSDT programs also provide a non-cash award program for providers/offices that meet specified goals for their patients' compliance with the receipt of EPSDT services. Non-cash awards include, but are not limited to, office luncheons, trophies or plaques, and recognition in Coventry member and/or provider newsletters.

Member Incentives:

Some states allow members to receive monetary awards, provided that they do not exceed certain monetary levels. These incentives may be in the form of coupons, discounts for services or goods, etc.

MCO Incentive Program:

The Medicaid population presents certain challenges in attaining standard EPSDT utilization levels. Health plans will expend considerable time, effort and money to attain reasonable EPSDT outcomes. Medicaid agencies help support these efforts by introducing health plan incentive programs. The Tennessee MCO incentive program should be well designed and include input from health plans and providers. Moreover, we strongly encourage the Bureau to develop a plan that will be rolled out gradually to support member, provider and health plan acclimation to the new program. Targets should be reasonable and incorporate standard measures, using data upon which all parties can agree. As the MCO incentive program matures, new benchmarks should be introduced to attain industry standard results. Funding for the TennCare incentive can be generated through deduction from the MCO capitation payments.

The health plan incentive program should have both financial and operational components. The State can reward the MCO financially for performance at certain levels. For example, if the target is 80% for well child visits for 3-6 year olds, then an incentive payment should be awarded for utilization rates above this benchmark. This approach works for any criteria deemed important to the TennCare program.

As is the case in a number of states, the Bureau may design an auto assignment algorithm that factors quality (i.e., EPSDT, HEDIS, CAHPS) and operational (i.e., timely claims payment, call center performance, data reporting, etc.) standards and physician access measures.

Coventry is well versed in meeting state performance benchmarks and is able to report on these programs in a variety of formats.

E. Utilization Management / Medical Management (UM / MM)

1. Benefit Limits Experience

Coventry health plans are adept at administering "hard" and "soft" benefit limits. Transportation services have been provided to members to go to the physician's and outpatient mental health benefits offices when non-urgent transportation was not a covered benefit. Alternatives such as, home health care are provided to members when appropriate when an inpatient confinement could be shortened. These decisions are routinely made by the case management staff with approval by the medical directors. Coventry understands the effective quality of care programs are not always well defined. Significant flexibility is granted the case management staff to affect a good outcome that may or may not be specifically defined by benefits and limits. An example of an application of hard benefit limits is in Michigan where up to 20 outpatient mental health visits a year are allowed for each MCO member. No exceptions may be made, and the state takes over management of the benefit if a member requires more than 20-visits or is deemed chronic.

A comprehensive utilization/medical management approach is a core competence of Coventry. Coventry has considerable experience managing diverse Medicaid benefits. Our utilization management approach encompasses a structured prior-authorization process, concurrent review and complex case management programs.

Prior-authorization: Key to Coventry's ability to manage health care is the prior-authorization process. Prior-authorization is a prospective process to ensure the proposed care is a covered benefit, medically necessary and delivered by a participating network provider. The prior-authorization process also includes obtaining demographic and clinical information from the requesting provider and filing the information into Coventry's database.

A distinct advantage of the prior-authorization process is that it makes possible alternative or supplemental interventions prior to the delivery of patient care. It is through the prior-authorization process that Coventry medical management staff members are able to evaluate the appropriateness of hard and soft benefits relative to specific individual care needs. A prior-authorization list for services is developed for each Coventry health plan, which is the basis for management of hard benefits and the determination of subsequent soft benefits as individual cases demand. This prior-authorization list is reviewed annually and may contain "hard" or "soft" benefits. All prior-authorization coordinators are fully trained and experienced in application of these "hard" or "soft" benefits limits. The following bullet points represent components of the Coventry prior-authorization process used to determine the scope/limits of benefits:

- Determination of member eligibility and verification of benefit coverage
- Verification of provider eligibility to ensure that the intended services will be provided by an appropriate network provider
- Confirmation that requested services are medically necessary and will be provided at the most appropriate level (in the office, outpatient or inpatient facility)
- Prior-authorization Coordinators apply nationally accepted standardized criteria (InterQual), in collaboration with a Coventry Medical Director to assure that all planned services are medically necessary and appropriate

- Notification to Coventry hospital based Concurrent Review Nurse that a member is to be admitted as an inpatient. The Concurrent Review Nurse, on admission, will begin monitoring the inpatient stay by reviewing the member's medical chart to assure that each inpatient day is medically necessary and appropriate for an inpatient level of care
- Identification of cases for which a Complex Case Management's intervention is appropriate. The Prior-authorization Coordinator can not ensure that members with complex and ongoing medical needs are appropriately evaluated for more intense medical management and follow-up
- Initiation of a discharge planning process simultaneously with the inpatient authorization. T he prior-authorization process is the ideal time to prepare a discharge plan, anticipate barriers to discharge and to arrange required services necessary for a timely discharge (home care, durable medical equipment, skilled nursing care)
- Diversion to a more appropriate setting. A request for inpatient services may be diverted to an ambulatory care setting or a case may be diverted from a nonparticipating provider to a participating provider. A member may also be diverted to a more qualified facility for specific diagnoses
- Collection of data for financial accruals and utilization reporting. By identifying the number and nature of hospital cases as well as potential catastrophic cases, Coventry can more accurately predict expenses
- Identification of quality of care issues
- Identification of outreach opportunities

The aforementioned process described is utilized in the application of soft limits when necessary. This same process is duplicated for any new Coventry Medicaid market, with customization to support local mandates. Prior-authorization is just one of three key strategies used by Coventry to effectively manage health care services. Assessment of soft limit needs via the prior-authorization process is supported by other key medical management functions. Other key utilization management strategies that support hard and soft benefit limit reviews include concurrent review and complex case management.

Concurrent Review: The goal of Coventry's concurrent review process is to ensure that all inpatient care is medically necessary, timely, and provided at the most appropriate level of care/setting. Further assessment for expanded soft benefit utilization is inherent in the concurrent review process. The efficient management of admissions is one of the most important aspects of controlling overall health care expenditures. Coventry believes that inpatient utilization reviews should be conducted daily to achieve optimal results. Coventry performs on-site and telephonic concurrent reviews on the majority of hospital admissions. Coventry concurrent review nurses also communicate frequently with attending and primary care physicians, as well as the health plan medical director, to gauge and coordinate additional service needs.

Complex Case Management: Complex Case Management (CCM) is a process that identifies, manages, monitors and provides reporting for the "sickest-of-the sick", those catastrophic cases or diagnoses that require extensive health services. The Coventry Care Coordination System is the support system for all CCM activities. The goal of CCM is to encourage the appropriate use of health care services. CCM is an individualized, patient-specific process that coordinates the delivery of cost-effective, high quality care

in the timeliest manner to ensure optimal patient outcomes. Specifically, CCM ensures the development and implementation of care plans unique to each member's needs.

2. Recommendations

Coventry is prepared to work with the State to implement defined utilization/medical management requirements. We recommend that Medicaid benefits defined by the State represent standard coverage levels. The MCOs should be granted flexibility to provide services based on medical necessity. This approach will allow MCOs to be creative and effective in servicing TennCare enrollees.

F. Disease Management (DM)

1. Experience with Formal Disease Management Programs

All Coventry Medicaid health plans offer DM programs in Diabetes, Asthma, End Stage Renal Disease (ESRD) and High-risk Obstetrics. All Coventry health plans have the ability to provide Congestive Heart Failure (CHF) programs, when it is indicated by the member population. In 2006, Coventry will implement formal Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease, HIV and Sickle Cell programs.

2. Program Arrangement

Coventry provides all DM programs in-house for medical care. Under behavioral health contracts, DM activities are delegated to the BHO. Integration occurs between health plans and BHOs to coordinate physical and behavioral health DM strategies. Coventry's approach to DM is to provide comprehensive care management to all members within target populations. The programs stratify members and provide interventions based on level of risk. Coventry's goals are to educate and empower members to care for themselves and to prevent acute events. Additionally, Coventry educates and supports physician participation through the annual distribution of our evidenced-based clinical guidelines, and DM program documentation. Coventry also sends physicians reminders about their patients in need of services related to their conditions, such as diabetic eye exams or corticosteroid therapy for asthmatics. The Coventry benefit structure is designed to support the guidelines used in all DM programs. The programs are designed to ensure all clinical recommendations reflect covered benefits. Coventry's DM programs are administered by local health plan Medicare directors and registered nurses.

3. Approach for Addressing Specified Conditions

For each DM program, members with particular conditions are identified via data extracted from our internal data warehouse. The information extracted is from claims, encounter and pharmaceutical data. Criteria used to determine DM program eligibility is based on HEDIS (i.e. Asthma, Diabetes) and Medicare (CHF) specifications. This process is conducted monthly to identify new members, as well as to identify potential risk stratification changes in the current members.

Identification and Stratification

Populations are stratified according to risk level. This is done so that the appropriate intervention can be tailored according to the needs of the member. The chart below details the stratification.

Risk Levels	Diabetes	Asthma	CHF
High	Complex Case Management (CCM) criteria (2 IP or 2 ER events within 6 months)		
Moderate	Newly identified in last month; ER or IP visit in last month; Recent CCM discharge or not admitted to CCM		
Low	All others with the condition		
Data Specifications	HEDIS without continuous enrollment	HEDIS without continuous enrollment	Medicare 2001 QAPI

Member Interventions

Interventions are evidenced-based and targeted to members' risk levels. This allows for a cost-effective approach, utilizing intensive tele-management for those in moderate to high risk groups. Furthermore, a reminder and education system is employed for members identified in the low risk group. The chart below details interventions by risk levels.

Risk Levels	Diabetes	Asthma	CHF	Frequency
High (All members in complex case management)	Complex case management- Individualized plans of care are developed to address specific member disease awareness and educational need. Co-morbidities are managed, if present.			As often as clinically determined
Moderate - Newly Identified with Condition	• Mail new member educational packet (Packet includes community resources, message about importance of regular visits with their practitioners, and advise to call practitioner if there are questions about the condition) • Telephone call to conduct short assessment and review self-care knowledge			Check for new members monthly
Moderate - ER visit in last month	• Mail letter tailored to address recent ER visit, including info about self-care, and follow-up with practitioner • Telephone call to conduct short assessment and review self-care knowledge • Mail educational packet, if needed			Once, follow-up as necessary
Moderate - Recent CCM discharge	• Telephone call to review treatment plan and conduct short assessment	• Telephone call to review treatment plan and conduct short assessment	• Telephone call to review treatment plan and conduct short assessment • Follow-up call to review weight, diet, medication compliance and exercise	Once, follow-up if necessary
Smokers	• Telephone call • Follow-up phone call • Mail smoking cessation resource materials			Once, follow-up as needed
All	• Mail brief brochure on diabetes self-care, including list of community resources for	• Mail brief brochure on asthma self-care, including list of community	• Mail brief brochure on CHF self-care, including list of community resources for	Annually

Risk Levels	Diabetes	Asthma	CHF	Frequency
	diabetes education • Mail reminders to those in need of eye exams, HgbA1c, lipid testing, or microalbuminuria testing • Mail 2nd reminders for above if necessary along with telephone reminders • Flu vaccine reminders • Pneumonia vaccine reminder • Mail list of members in need of services to PCPs • Provide glucose meter • Provide reminder stickers to practitioners. • Provide information on benefits available for diabetes care. • Holiday reminders about appropriate nutrition and food choices. • Cholesterol management education to LDL > 130 mg/dL	resources for asthma education • Mail tailored letter to members without a prescription for inhaled corticosteroids • Flu vaccine reminder • Pneumonia vaccine reminder if >65 years • Mail list of members without a prescription for inhaled corticosteroids to PCPs, include a program description in mailing	CHF education • Flu vaccine reminder • Pneumonia vaccine reminder • Mail list of members with CHF without a prescription for ACE inhibitors to PCPs, include a program description • Holiday reminders about appropriate nutrition and food choices	

Approach to Provider Engagement (Behavior)

The cornerstone of Coventry's successful DM programs is the engagement of provider support. Provider resources are pivotal in data collection, reinforcement of positive member behavior and monitoring outcomes. Interventions include the following:

- Annual distribution of the clinical practice guidelines
- Annual distribution of the program description and referral process
- Letters to physicians listing their members who are in need of disease-specific services such as eye exams, flu shots, left ventricular function assessment (LVFA), etc.

Outcomes

The effectiveness of Coventry's DM programs is measured by standard indicators that determine appropriate care delivery and patient improvement. The following chart represents a sample of indicators that are measured:

Condition	Clinical Measures	Data Sources
Diabetes	Adults 18 years and older- ▪ Eye exam within last year ▪ 2-4 HgbA1c within last year ▪ HgbA1c values ▪ Lipid profile within last year ▪ Microalbuminuria within last year ▪ Smokers referred to classes/counseling ▪ Smokers who participated ▪ Annual flu vaccine ▪ Pneumonia vaccine ▪ PMPM costs	DM Cube Case managers/ Disease Managers (smoker information)
Asthma	All ages ▪ Admission within past year per 1000 members ▪ ER visits within past year per 1000 members ▪ Inhaled corticosteroids and leukotrienes (ICS/LKA) ▪ ICS/LKA and ER visit ▪ Smokers referred to classes/counseling ▪ Smokers who participated ▪ Flu vaccine ▪ Pneumonia vaccine if > 65 years ▪ PMPM costs	DM Cube Case managers/ Disease Managers (smoker information)
CHF	Adults 65 years and older - ▪ ACE inhibitor ▪ Beta blocker ▪ LVF assessment ▪ Admissions within the past year per 1000 members ▪ Readmissions within the last six months per 1000 members ▪ Length of time between admissions ▪ Smokers referred to classes/counseling ▪ Smokers who participated ▪ Annual flu vaccine ▪ Pneumonia vaccine ▪ PMPM costs	DM Cube Case managers/ Disease Managers (smoker information)

Other Care Management Programs

a. High-risk Obstetrics

The goal of the Obstetrics Case Management Program is to positively impact high-risk OB outcomes and ensure delivery of healthier newborns. All high-risk OB members are managed by a Complex Case Manager. The case manager, using an assessment tool completed by the member's physician, identifies high-risk obstetrical cases. Those identified as high risk are provided telephonic nurse case management. The successful implementation of the program interventions has led to a reduction in premature deliveries. Interventions provided include the following:

- Education on prenatal care, diet, exercise, and signs/symptoms of premature labor
- Smoking cessation, if applicable
- Coordination of care with the physician
- Screening for use of premature labor medication (17P) to prevent premature births
- Special education for those with Gestational Diabetes, Hyperemesis Gravidarum, Multiple Gestations, or Pregnancy-Induced Hypertension
- Referrals to community-based services (i.e. WIC, MSS/ISS)

b. End stage renal disease (ESRD)

Coventry also has a care management program for members with end stage renal disease. All members currently on dialysis or scheduled to begin dialysis are included in the program. We also identify eligible members from a variety of other sources such as administrative data systems, physician and home health referrals, and nurses reviewing inpatient cases. Members receive individualized nursing care via telephone outreach. All members diagnosed with ESRD are considered high risk. Their care is coordinated by complex case managers and they receive the following services/support:

- Clinical need assessment (i.e., application of soft benefit)
- Nurse care management based on ESRD guidelines
- Nurse care management for co-morbidities, such as diabetes, hypertension and CHF
- Monitoring of outpatient placement of vascular access and outpatient de-clotting of grafts
- Monitoring of compliance with early testing (two weeks prior to initiating dialysis) of Hepatitis status
- Review of medications and member education on use
- Coordinate care with nephrologists
- Educational materials on ESRD-DM
- Monitoring of lab results
- Monitoring member compliance with prescribed dialysis schedule
- Monitoring for anemia, bone disease, fluid and dietary compliance
- Smoking cessation counseling
- Monitoring hemodialysis adequacy
- Education about the importance of receiving pneumonia and annual flu vaccines

<u>ESRD Program Outcomes Measurement Criteria</u>:

- Laboratory tests quarterly
- Vascular access
- Hospital admits per patient/per quarter (per pt/qtr)
- Bed days (per pt/qtr)
- Emergency Department visits per qtr
- Average Length of Stay (ALOS) days/admits
- Bed days by reason for hospitalization
- 23 hour stays (per pt/qtr)
- Skilled nursing bed days (per pt/qtr)

Program Populations

Diabetes Mellitus
Currently there are 4,240 members in Coventry's Diabetes management programs.

Congestive Heart Failure
Currently there are 316 members in Coventry's CHF management programs.

Asthma
Currently there are 19,753 members in Coventry's Asthma management programs.

High-risk Obstetrics
Currently there are 719 members in Coventry's High-risk OB management programs.

2006 Programs Covering High Cost Utilization Trends

a. Coronary Artery Disease (CAD)

All members with a diagnosis of CAD will be identified and segregated into two risk groups: High risk (Inpatient event with CAD and seen in physician's office) and low risk (members with CAD and seen in physician's office). Additional members will be identified through physician referrals, concurrent review and HRAs.

Member Interventions
Educational intervention efforts are provided according to the risk levels below:
Low risk: Educational mailings on self-care management, including diet and exercise. Smoking cessation information is provided, if applicable. Partnerships with community organizations will be developed to improve the education to members with CAD.

High risk: Members, who are at high risk for complications from CAD, are provided complex case management. Individualized plans of care will be developed to address the member's CAD awareness and educational needs. Co-morbidities, if present, will be managed. Care will be coordinated with the physician, if necessary.

Provider Interventions
Interventions aimed at providers include the annual distribution of the clinical practice guidelines and program description, which describes the referral process. Additionally, routine notices will be sent to physicians identifying members in need of disease-specific services such as flu shots, cholesterol checks, etc.

CAD Program Outcomes Measurement Criteria:
- Prescription for ACE Inhibitor/ARB/Beta Blocker
- Annual cholesterol, particularly LDL
- Hospital admits per pt/qtr
- Bed days (per pt/qtr)
- Emergency Department visits per qtr
- ALOS days/admits
- Influenza vaccine
- Pneumococcal vaccine

b. Chronic-Obstructive Pulmonary Disease (COPD)

All members with a diagnosis of COPD will be identified and segregated into three risk groups: high risk (2 or more acute events within the past 6 months); moderate

risk (1 acute event within past month); low risk (all others). Additionally, members will be identified through physician referrals, concurrent review and HRAs.

Member Interventions
At all levels, members will receive at a minimum all services identified within the low risk category. Educational intervention efforts are provided based on the member's risk level as follows:
Low risk: Educational mailings on self-care management; telephone or mailed reminders to see their physicians; reminders about proper utilization of prescriptions; smoking cessation information.
Moderate risk: Newly identified members receive a new member packet that includes self-care management guidelines; list of community resources; and advise about when to call their physicians. A member, who has been in the emergency room or hospitalized within the past month, receives a telephone call or a special mailing about self-care management; and a recommendation to see his/her physician. The member also receives all the interventions established for the risk group.
High risk: Members categorized as high risk are provided complex case management support. Individualized plans of care are developed to address the members' COPD awareness and educational needs. Co-morbidities are managed, if present.

Provider Interventions
Interventions aimed at providers include the annual distribution of the clinical practice guidelines and program description, which describes the referral process. Additionally, routine notices will be sent to physicians identifying members in need of disease-specific services such as flu shots, pulmonary function tests, etc.

COPD Program Outcomes Measurable Criteria:
- Prescription for inhaled corticosteroids and/or long-acting beta agonists and anticholinergics
- Annual pulmonary function test
- Hospital admits per pt/qtr
- Bed days (per pt/qtr)
- Emergency Department visits per qtr
- ALOS days/admits
- Influenza vaccine
- Pneumococcal vaccine

4. Care Management for Behavioral Health (BH) Conditions
Coventry has behavioral health care management programs in all of its Medicaid markets where behavioral health benefits are included in the MCO contract. In addition, Coventry's Pennsylvania health plan is contracted with the state for behavioral health services in one region.

5. BH Care Management Program Arrangement
Coventry health plans subcontract with accredited BHOs, for the provision of covered behavioral health services. Generally, treatment provisions for chronic and acute behavioral health conditions as defined by each state, and substance abuse services, are carved out of Medicaid contracts in Coventry markets. Basic mental health treatments are typically included in the Coventry Medicaid MCO contracts.

The BHO Disease Management – An Overview

Disease management begins with a detailed history of the disease and treatment, so that the current situation can be assessed in the context of the member's past experiences, triggering events/conditions, and responsiveness to previous medications and clinical therapies. The history will include pertinent medical events, co-occurring mental illness or substance abuse, and a psychosocial history.

Diagnosis

An accurate diagnosis follows the detailed history intake. It is the responsibility of the provider to assign treatment diagnoses based on presenting problems, appropriate testing, and the aforementioned member history. The BHO Clinical Care Manager will, uphold the MCO's responsibility to ensure that the diagnosis is consistent with the presenting problems and information obtained from prior treatment experiences. If the diagnosis is questioned, the BHO may assign a peer advisor (Medical Director or contracted physician reviewer) to discuss the provider's decision or perform additional diagnostic measures.

Specific Treatment Planning

The level of care must be consistent with the Medical Necessity Criteria endorsed by the BHO, and approved by the state Medicaid agency. If the member calls the BHO directly, rather than initiating services via from an MCO provider, the Clinical Care Manager will make a tentative determination based on the initial screening and the treatment history within the Clinical Data module. The level of care will then be finalized through consultation between the BHO and the ultimate provider. The level of care determination is followed by a detailed treatment plan submitted by the provider, which includes specific treatment objectives based on the identified strengths, needs, and presenting problems. The decision will be made in the context of response to care during previous, similar disease episodes, if such have been recorded.

Monitoring and Case Review

During the concurrent review process, the BHO's Clinical Care Managers help the provider and member to focus on treatment objectives and attainable outcomes/goals while emphasizing discharge planning and after-care coordination. The BHO works with the provider to develop a comprehensive treatment plan that includes:

1. A comprehensive bio-psychosocial assessment;
2. Defined treatment interventions targeted at specific signs and symptoms presented by the member
3. Differentiation of long- and short-term goals;
4. Measurable objectives with reasonable treatment length
5. Realistic treatment expectations
6. Specific discharge planning
7. Evidence of member and family participation in treatment and after-care, and
8. Proper treatment of co-occurring addictive disease issues

Providers are required to routinely assess member care progress, based on long and short treatment goals. These goals should be developed with the member (and family if appropriate) and be designed and written such that the member can state at discharge whether his or her goals have been attained; and whether the member believes that the therapeutic intervention has been useful. If the current therapy has been effective in meeting most of the objectives, the BHO and the provider will consider whether to

provide ongoing care at a less intensive level of care. For example, a member that has achieved many treatment objectives in partial hospitalization may be continued in outpatient treatment. If the provider is a multi-service, multi-level treatment facility, the optimum approach will be to keep the member in treatment with the same provider, to easily facilitate confidential record transfer. If necessary, the BHO will make arrangements for transfer to a new provider. This entails requiring that all necessary releases be obtained so that the receiving facility may request and receive clinical records. The BHO ensures that all members discharged from an inpatient level of care have appointments made for continuing care prior to their discharge.

Members that are responding to therapy satisfactorily, but have not yet reached most objectives will continue care upon mutual agreement of the BHO and provider. Providers will be required to adjust specific therapies for members whose conditions do not improve, keeping within the same level of care as authorized. Finally, members whose conditions worsen will be assigned to a more intensive level of care to address the presenting needs.

Follow-up
Member follow-up, with the collection of outcome measurement results, is the concluding step for each episode of care in the disease management process. The Provider Agreement requires providers to furnish the BHO with outcome measures, including the health plan's performance outcome measures, children's outcome instruments, and other indicators as specified by the Quality Improvement Department. Providers must submit objective, measurable outcomes related to defined care and are required to demonstrate that persons receiving the care benefit from the prescribed therapies. Outcome information is gathered during the course of treatment as well as at its conclusion to facilitate the best progress for the member. Reports are available for the providers regarding the outcome improvement shown by members in their care. By analyzing the measurements in comparison to member characteristics, treatment history, diagnostic information and therapeutic intervention, the BHO works with providers to optimize guidelines for best practices. All guidelines that are evaluated and considered helpful are made available as a reference to providers to guide practice.

Coventry requires contracted BHOs to demonstrate successful DM administration similar to its clinical management programs. This is accomplished by requiring strong partnerships with mental health providers, PCPs, and emphasizing medical community awareness of certain mental health diseases. Coventry also requires the BHO to conduct member education on symptoms and care as well as support provider treatment plans. BHO case managers proactively identify members with documented or suspected diagnoses of certain diseases and work with them and their behavioral health and/or medical providers to develop comprehensive treatment plans. As a team, the BHO and the treating practitioners assess the member's mental health status, treatment progress and goals, medication management, and how best to move forward with care planning. The goals of these programs are to ensure a decrease in disease symptoms and enhance the member's level of functioning.

The BHO is required to employ intensive case management protocols for all members requiring mental health services, resulting from an Axis I diagnosis and the presence of complicating factors that without intensive intervention would result in further condition deterioration. Coventry insists that BHOs have diagnosis-specific protocols to assist Coventry clinical staff in managing members with complex treatment needs. To ensure

proper coordination, BHO clinical staff members participate in the development and oversight of quality improvement programs by serving on health plan Quality Improvement Committees.

As part of health plan Quality Assurance programs, routine monitoring of BHO performance is conducted. Reviews are completed on quality improvement activities, utilization management, outcomes, and overall contract compliance. Additional programs or modifications to existing BHO programs are recommended by Coventry. Health plan recommendations must be incorporated into BHO quality improvement initiatives.

6. BH Care Management Approach for Addressing Specified Conditions

Generally, treatment provisions for chronic and acute behavioral health conditions are carved out of Medicaid contracts in most Coventry markets. Treatment of conditions such as schizophrenia, bipolar disorder, major depression, and co-occurring mental illness/substance abuse are the responsibility of the state Medicaid agency and its behavioral health delivery system. The exception is the Coventry Pennsylvania health plan. Its behavioral health care management approach is detailed below.

Identification of Individuals in Need of Interventions

Coventry Pennsylvania's BHO and CBHNP provides Clinical Practice Guidelines to its provider networks. Clinical Practice Guidelines are evaluated through the BHO Provider Advisory Committee (PAC). The PAC has adopts Clinical Best Practice Guidelines to serve as benchmarks for quality improvement initiatives. The PAC includes representation from BHO provider groups as well as clinical staff. It meets to consider proposals for new services and to consider adoption of clinical practice guidelines. The committee has focused on the most common diagnoses seen in the enrollee population. The committee has adopted six clinical practice guidelines, and measures have been developed for two of them.

The QI Committee delegates responsibility for the evaluation of Clinical Practice Guidelines to the PAC. Six Clinical Practice Guidelines have been evaluated and recommended as relevant for the BHO Provider Network:

Major Depression. Adopted the American Psychiatric Association Practice Guideline for the Treatment of Patients with Major Depression (2nd. Ed. April, 2002, Updated 09/2005).
Attention Deficit Hyperactivity Disorder. Adopted the American Academy of Pediatrics Clinical Practice Guideline: Diagnosis and Evaluation of the Child with Attention-Deficit/Hyperactivity Disorder (Pediatrics 105:1158-1170, 2000, Updated 09/2005).
Attention Deficit Hyperactivity Disorder. Adopted the American Academy of Pediatrics Clinical Practice Guideline: Treatment of the School-Aged Child with Attention-Deficit/Hyperactivity Disorder (Pediatrics 108:1033-1044, 2001, Updated 09/2005).
Substance Use Disorders. Adopted the American Psychiatric Association Practice Guideline For The Treatment Of Patients With Substance Use Disorders: Alcohol, Cocaine, Opioids (1995, Updated 09/2005).
Bipolar Disorders. Adopted the American Psychiatric Association Practice Guideline for the Treatment of Patients with Bipolar Disorder (Revision 2002, Updated 09/2005).
Schizophrenia. Adopted the American Psychiatric Association Practice Guideline for the Treatment of Patients with Schizophrenia, 2nd Ed., (Revision 2004, Updated 09/2005).

The CBHNP measures the performance of the provider network against Clinical Practice Guidelines in the following manner for Bipolar Disorder treatment and in a similar manner for other diagnoses:

APA Practice Guideline for the Treatment of Patients with Bipolar Disorder

1) Acute and maintenance treatment options with the best empirical evidence to support their use include lithium or valproate (Depakote); possible alternatives include lamotrigine (Lamictal), carbamazepine (Tegretol), or oxcarbazepine (Trileptal).
   Measure:
   - Identify all members with Bipolar Disorder diagnoses (296.4x; 296.5x; etc.) who had at least one claim for a medication management visit (90862) in an identified one-year period of time.
   - Identify the MCO for each identified member.
   - For the same annual period, request pharmacy data from the MCO for each identified member for the following medications: lithium, valproate, lamotrigine, carbamazepine, and oxcabazepine.
   - Determine the percentage of Bipolar Disorder patients who are prescribed at least one of the first-line medication options recommended by the guideline.

2) Bipolar disorder with a co-morbid substance use disorder is a very common presentation, with bipolar disorder patients showing much higher rates of substance use than the general population. As a benchmark, the Epidemiologic Catchment Area (ECA) study found rates of alcohol abuse or dependence in 46% of patients with bipolar disorder compared to 13% for the general population. Comparable drug abuse and dependence figures are 41% and 6%, respectively.
   Measure:
   - Identify all members with Bipolar Disorder diagnoses (296.4x; 296.5x; etc.) who had at least one claim for any service in an identified 1-year period of time.
   - Identify secondary diagnoses of the following Substance-Related Disorders (303.90; 305.00;etc.) and/or Substance Abuse treatment authorization within the same annual time period.
   - Determine the percentage of Bipolar Disorder patients who are also diagnosed and/or who have been treated for substance abuse or dependence as recommended by the guideline.

The Bipolar Disorder DM guidelines in addition to the following components constitute the complete DM/Case Management approach. These components apply to other disorders as well.

Other Components Common to all PA-BHO DM/Case Mgmt. Programs	
Outreach and Education Approach	*Public Education and Training* The first priority of the public education program will be to highlight the services available through the BHO. It is also important to inform members about their rights and responsibilities as consumers. One such responsibility that will be stressed in the training is that members are partners with providers in maintaining behavioral health. Wellness topics and mental health and substance abuse prevention information will be included. Education about the availability of appropriate levels of care will be highlighted with an emphasis on getting appropriate help in a timely manner.

Other Components Common to all PA-BHO DM/Case Mgmt. Programs	
	Member Orientation The CBHNP has completed the orientation for members, public education programs expand to include other training for key stakeholders such as family members, providers, religious leaders, community service center staff, and school personnel. The Public Education and Training Plan (PETP) assists stakeholders in recognizing behavioral health needs before they reach a crisis stage and helps to familiarize members with community resources and plan benefits. The following outreach services are available to all members who fall into these special categories or are presenting symptoms that would warrant such care: • *Targeted Case Management* - This approach includes assistance with securing safe living arrangements, financial entitlements, legal aide, medical and/or psychiatric/chemical dependency treatment, in-home support or children's respite services, and transportation services, as necessary. All of these services are aimed at decreasing use of ER and inpatient services, and at helping the person to manage his/her mental illness with increasing independence and decreased reliance on paid caregivers. • *Psychiatric/Medical Services* - Offers medication administration and monitoring by psychiatric nursing staff. • *Crisis Mobile Outreach* - Utilized to assist in the assessment of an emergent or urgent situation and will implement short-term treatment plans to stabilize the presenting symptoms until more traditional treatment can be accessed.
Approach to Co-Morbid Mental and Physical Conditions	In PA, the cbhnp participates with the physical health plan in managing co-morbid conditions. A letter of agreement establishes mutual roles, with both PCPs and psychiatrists performing evaluations trained to identify co-morbid conditions. Coordination across entities is accomplished through a comprehensive reporting process that includes detailed accounting of authorizations, encounters, and paid claims. The behavioral health entity maintains detailed medical histories for members that include PCP notes, medication, hospitalizations, etc. Any time a diagnosis, treatment, or outcome has implications for the member's medical condition, the provider or MCO is informed. Often, individuals may be treated concurrently in a behavioral health unit of a general hospital or in a medical detox unit. Individuals will otherwise be placed in treatment on the basis of acuity. Life threatening medical conditions is a priority with the intent to treat behavioral disorders simultaneously to ensure proper coordination and follow through.
# Eligibles Supported	130,000 Medicaid recipients in the contracted PA region.
Approach to Provider Behavior	CBHNP contracts only with entities that are state licensed. CBHNP has a rigorous credentialing and re-credentialing process. In addition, all facility providers must complete and submit an application that requires disclosure if there has been prior expulsion from participation in any insurance and/or HMO program. The facility provider should also have maintain:

Other Components Common to all PA-BHO DM/Case Mgmt. Programs	
	• An admissions policy free from restrictions based on race, religion, color, creed, sex, sexual preference or national origin • Multi-disciplinary treatment staff • Availability of 24-hour emergency services and medical emergency room back up • Policy for credentialing clinical staff. The policy will be reviewed by the BHO • Description of all language capabilities and ability to treat special populations Initial site visits will be required for any non-accredited or potential high volume providers. The initial site visit will occur prior to the credentialing decision. The visit includes evaluation of the facility for accessibility, appearance, adequacy of waiting and treatment rooms, appointment availability, and appropriate treatment record keeping practices. If the provider site does not meet thresholds for acceptable performance, CBHNP will notify the site of deficiencies and re-evaluate within six (6) months or sooner if requested. This will occur every six (6) months until the provider meets the threshold. BHO requires all providers to report critical incidents, such as member death, medication error, etc. The CBHNP may then require a corrective action plan to prevent further occurrence. The BHO regularly performs record audits and on-site visits to ensure quality of documentation and treatment. All member complaints about providers are reviewed and logged. All information gathered from the above activities are maintained as part of a provider profile, which can influence re-credentialing, contracting, and referral practices.
Staff Qualifications	CBHNP staff involved in clinical care decisions are licensed professionals. This includes registered nurses, psychologists, social workers and psychiatrists. Only psychologists and board certified psychiatrists may deny requests for care on the basis of medical necessity criteria.
Managing within benefit levels	CBHNP has experience managing within benefit limits, member services staff are trained to identify community resources to support out-of-plan services.

G. Capitation Model

1. Risk Contract Experience

Coventry has over twenty-five years experience operating in a full risk environment. Multiple populations have been served, ranging from TANF to dual eligibles. The traditional model capitates health plans based on rates developed for multiple age/sex/program rate cells.

The capitated model proposed by the State of Tennessee is an effective way to compensate health plans to serve its multidimensional Medicaid population. However, there are key areas that require special attention. It is important that the State establish the rate of reimbursement to be paid to providers under contract with health plans. If

these rates are not established, some providers may be reluctant to execute contracts with MCOs. This behavior will ultimately impede the success of the program. The cost of care will increase, thereby placing the program and health plans at financial risk. In addition, if significant numbers of providers do not contract with MCOs, voluntary admissions will be limited to participating providers. This could adversely affect member access to care. The recommended approach is to establish a policy that non-participating providers will be reimbursed at 90% of the State Medicaid FFS schedule.

Additionally, the Bureau should consider inclusion of a diagnostic acuity factor in the rate calculations, for those populations that require costlier and more complex care. There is also a geographic factor to be considered in the level and complexity of services provided. Urban settings generally have tertiary facilities that attract members with more complex/severe illnesses. As a result, health plan rates must be representative of the cost for caring for these chronically and critically ill beneficiaries. Failure to adequately address these critical rate development factors has contributed to health plan financial distress in various states.

2. Full-risk Capitation Environment

A full-risk capitation environment would be attractive to Coventry. Coventry is experienced operating in a risk environment. The key factors in the development of an effective full risk program have been addressed in the preceding passage, but bear repeating. Established rates must be fair, reasonable, and reflective of the acuity of care for the enrolled population. Further, it is important that rates meet the CMS requirement of being actuarially sound.

3. Alternatives to Full-risk Capitation

A stop loss program is unnecessary if the Bureau implements a diagnostic acuity adjuster program for certain populations, such as dual eligibles, ABAD, and other high risk related groups. Furthermore, risk assumption works better when there is significant health plan membership to spread the risk. As such, the number of enrollees per health plan, based on market factors and specific criteria, should be established by the Bureau. We recommend a 50,000 member threshold.

If a minimum member threshold is established, it may not be necessary to define soft benefits in a risk-based environment. Furthermore, it is unnecessary to develop aggregate risk sharing with soft benefit limits under the minimum enrollment threshold scenario.

We recommend that the Bureau develop special rates for maternity care, referred to as “Kick” payments. These payments are issued upon notification to the State of a delivery. Kick payments are appropriate in situations when expectant mothers are enrolled into health plans after the second or third trimester.

4. Minimum Number of Covered Lives

Some Coventry health plans have low Medicaid enrollment in proportion to the number of managed care eligibles in their service areas. However, in these instances, commercial and Medicare products are also administered by the health plan. It is Coventry’s intent, if awarded a TennCare contract, to establish a Medicaid-only health plan. This requires considerable resources and infrastructure development. As such, our preference for minimum enrolled membership is 50,000 lives.

H. Data and Systems Capability

1. Data and Reports for External Monitoring

Coventry utilizes various internal databases and warehouses to produce reports for its state Medicaid markets. Databases include *Navigator* (Customer Relationship Management database), *CDW* (Coventry Data Warehouse), and *CPD* (Coventry Provider Database). Via the use of these databases/warehouse, all Coventry Medicaid health plans are able to produce comprehensive operational reports to support external monitoring activities. These reports include, but are not limited to, encounter data, HEDIS, claims activity, financial and other pertinent reports required by individual state market. Listed below are examples of core data reporting activities conducted in Coventry Medicaid markets, to comply with state external monitoring requirements.

Encounter Data Reporting. Coventry successfully transmits encounter data to all of its Medicaid state agencies, in accordance with unique specifications by state. In 2004, Coventry processed several million claims, as well as a comparable number of pharmacy and encounter claims, for each Medicaid contract in the specific market format. Coventry's submission of encounter data information to various Medicaid agencies is not only complete, but timely as well. Encounter claims data is generated from a variety of sources, not limited to, vision, pharmacy, lab, and mental health services; as well as data from state immunization registries. Data submitted to states for external reporting purposes are also the basis for the development of HEDIS reports, which are submitted to state agencies to satisfy utilization reporting.

Encounter data include information on immunizations, well child visits, and other medical services received by Coventry Medicaid plan enrollees in each of Coventry's eight markets. Encounter data within *CDW* are accumulated from Coventry and subcontractor claims data. The frequency and type of information reported to each state varies. For example, Missouri encounters are reported on an on-going basis and include both statistical (capitated PCP encounters) and paid medical, pharmacy, dental, transportation, and behavioral health claims processed.

External Quality Review (EQR)/Quality Improvement Activities. EQR-related activities are reported to state Medicaid agencies in Maryland, Michigan, Iowa, Virginia, West Virginia, North Carolina, and Missouri. Coventry Medicaid health plans have experience in the development and administration of Performance Improvement Projects (PIPs), as a component of EQR activities defined by the CMS guidelines. Quality improvement staff at each Coventry Medicaid health plan develop PIPs and other quality improvement related reports/protocols, based on utilization trend data obtained from *CDW*. Reporting of such initiatives and related data is done generally via Quality Assurance programs (QAP), annual program evaluations, and QAP work plans. The Quality Department at each Coventry Medicaid health plan defines the key areas to be monitored, such as EPSDT (including lead screening), DM, and adverse events. Quality improvement reporting is also used to identify target populations for focused studies by prevalent disease category or any other condition identified for improvement, in accordance with State guidelines.

Provider Information. Coventry has significant experience in the exchange of its contracted provider panel information electronically within all of its Medicaid markets. An

internal database, Coventry Provider Database (CPD), is utilized to maintain provider information for over 15,000 Medicaid providers in previously identified Coventry Medicaid markets. This application captures key provider information (PIN, multiple office addresses, products, practices, etc.), ensuring data quality and preventing duplication. Though the CPD is a database, it utilizes certain functionality to validate the data at the time information is being loaded. In addition, CPD has the capacity to generate output reports which are utilized in the transmission of provider files to state enrollment brokers and/or Medicaid agencies directly. The following represents some of the capabilities of CPD:

- Verify provider addresses with the United States Postal Service (USPS)
- Verify the credentials of providers in compliance with NCQA standards
- Produce electronic (Web-based) and printed provider directories
- Link a provider to product and fee class (for specific market)
- Manage reciprocity agreements

Fraud and Abuse Detection and Reporting. Coventry maintains a Special Investigations Unit (SIU) which monitors provider anti-fraud and abuse activities. The SIU staff reviews historical claims detail and provider billing behavior for suspicious patterns or activity. SIU staff utilizes various tools to analyze retrospective claims data, as a method of identifying irregular or suspicious practice patterns. Monthly reports are generated by SIU for each Coventry Medicaid health plan, documenting the number of claims reviewed, providers listed in the suspect queue, number of medical charts requested, and dollars for potential recovery.

Local health plans are responsible for the development and implementation of tools to detect, prevent and report member, employee and subcontractor fraud and abuse. All Coventry Medicaid plans comply with requisite state fraud and abuse reporting. Any identification of fraud and/or abusive behavior is reported to the appropriate State and federal authorities as required by law and contract**.**

Standard Administrative Reports. Each of Coventry's eight Medicaid health plans is capable of satisfying proprietary contractual reporting requirements. However, there are some standard reports that are generated for Coventry Medicaid markets, as may be required by contract. Some of the standard administrative reports generated include the following:

- *Grievance and Appeal Reports* – Coventry maintains a customer relationship management system, *Navigator*, which is used to track and trend member complaints/inquiries/grievances and appeals for all Medicaid markets. The system allows for the generation of reports on the type of issues presented, volume, and turnaround time for resolution. Data generated from this system is submitted to state Medicaid agencies to satisfy grievance and appeal reporting requirements.
- *Claims Timeliness Reports* - Reports are generated utilizing data from IDX, Coventry's claims payment system, to demonstrate turnaround times for adjudication and payment of claims. Claims timeliness reports for Coventry's North Carolina Medicaid plan are generated by its administrative subcontractor, EHS.
- *Financial Reports* – All Coventry Medicaid health plans adhere to financial reporting requirements as indicated by NAIC and adopted by each state.

Financial reporting is done quarterly and annually, consistent with individual state Medicaid contract guidelines.

- *Provider Network Adequacy and Capacity Report* – Provider network adequacy and capacity are measured in the Michigan, Maryland and Missouri markets. Via transmission of electronic provider files, state officials measure the overall network for PCP participation, as well as specialty coverage for select service areas. This information is utilized in the enrollment assignment activities conducted by each state's Medicaid agency.
- *Third Party Liability and Coordination of Benefits Report* – Coordination of benefit activities are reported for all Coventry health plans. Reports are submitted quarterly or annually as defined by state guidelines.

Any transmission of electronic information, such as encounter and enrollment, utilizes HIPAA transaction formats. Coventry Medicaid plans are also capable of transmitting data in proprietary file layouts, as required by state Medicaid agencies.

2. Data Regarding MCO, Provider, and Subcontractor Performance

Coventry utilizes standard data tools to monitor and measure each of its individual Medicaid health plan's performance. Health plan performance measurement activities are also extended to include the activities of each Coventry network provider. Standard utilization and financial reports are utilized by all Coventry plans to assess operational performance. Qualitative performance is measured for each Coventry Medicaid health plan and its provider panel, utilizing standard industry tools, such as HEDIS and CAHPS reporting. Additionally, this reporting is complemented by internal surveys and other case management tools, allowing for greater review of provider performance.

Monthly Operational and Financial Reporting. Each Coventry Medicaid health plan maintains monthly operational and financial reports to track key indicators such as days per 1000, ALOS, and claims/capitation payment per program category. Claims and encounter data used to assess such indicators are generated from *CDW.* Monthly, quarterly, and annual reports are maintained to measure individual health plan performance against corporate financial and operational goals.

HEDIS® Reporting. Coventry has significant experience in generating and reporting HEDIS measures. In 2005, HEDIS administrative rates were generated for 15 Coventry health plans, with approximately 30 different products/breakouts. In 2005, HEDIS reports were generated for the Michigan, Iowa, Virginia, West Virginia, North Carolina, and Missouri Medicaid markets, as required by contract. Coventry utilizes the Quality Spectrum application from Catalyst Technologies, Inc., an NCQA certified HEDIS software vendor, to generate rate and utilization measures for all Medicaid health plans. Consistent with regulatory requirements, CAHPS and NCQA HEDIS audits were administered via a centralized contract/process with an NCQA Certified Survey vendor and a HEDIS Audit firm. Coventry uses its internal database, *CDW,* as the primary data source to support HEDIS reporting. The process is audited according to NCQA HEDIS Compliance Audit™ specifications.

CAHPS. Coventry Medicaid health plans conduct CAHPS surveys as required by contract. Coventry uses an external vendor to administer the survey and tabulate findings. Each Coventry Medicaid health plan's Quality Improvement Department is responsible for survey review and development of improvement plans to address any identified deficiencies.

State Report Cards. A further complement to CAHPS survey results are state report cards generated in specific markets. Coventry Medicaid plans in Michigan, North Carolina, Missouri and Maryland all participate in report card systems, aimed at demonstrating plan performance relative to state benchmarks for encounter data, HEDIS, CAHPS, and other specific indicators.

CSO Internal Surveys. Internal surveys are conducted annually by Coventry's Customer Service Operations (CSO) division, to assess consumer and provider satisfaction with health plan and CSO services. Members and providers from all Coventry Medicaid health plans are solicited to participate in the Annual CSO Satisfaction Survey. Results are utilized internally for identification of process improvement opportunities and service expansion. Results are further analyzed for trend comparison to telephone inquiry reports produced in Coventry's *Navigator* system. *Navigator* tracks all inquiry, complaint, and grievance contacts to Coventry's customer service unit for each Medicaid market.

COGNOS Reporting. Coventry Medicaid health plans may utilize *COGNOS*, a decision support and clinical information portal, which provides data for use in utilization management and quality improvement administration. This system is also useful in the development of provider profile reporting.

I. Net Worth and Restricted Deposit Requirements

The State of Tennessee proposes compliance with both the statutory net worth requirements as well as restricted deposits, based on projected membership and revenue. It is our understanding that the restricted deposits can be used to meet the statutory net worth requirements. Therefore, the net worth and depositing requirements as stated in the State of Tennessee Department of Commerce and Insurance regulations and TennCare MCO contracts are not deterrents to our desire to participate in TennCare. The following points represent Coventry's commitment to the financial stability of its local health plans:

1. *Coventry is committed to achieving and managing to at least 250% of regulatory risk based capital (RBC) at each regulated subsidiary.*
2. *Coventry will also ensure the solvency of any subsidiary managing Medicaid programs through parent guarantor agreements or purchase of insolvency insurance, if required.*
3. *Coventry has the financial ability and intention of supporting regulated subsidiary health plans with capital contributions as required*.

We understand that the intent of net worth and restricted deposits requirements are to protect the State of Tennessee, and TennCare program providers and members. These protections can also be provided contractually by stipulating the specific requirements within boilerplate agreements executed between MCOs and providers. All Coventry provider contracts include insolvency protection language.

J. Implementation Timeframe

1. Impact of Anticipated Timeframe

We look forward to the opportunity to partner with the Bureau and to bring Coventry's proven Medicaid managed care model to Tennessee. The proposed timeframe for contract award and implementation is aggressive and must be factored into our decision to enter the market. As we would be establishing a new organization in the state, there are significant start-up activities which need to be factored into our strategic plan, which are summarized below:

- Obtaining appropriate state licensure and certificate of authority (COA)
- Establishing an office in the Tennessee Middle Region
- Staff recruitment and training
- Recruit and credential a comprehensive provider network to ensure high quality care for TennCare beneficiaries
- Design and implement TennCare specific MIS applications; inclusive of necessary electronic interfaces with TennCare information system
- Establish relationships with key community stakeholders

The Bureau and Department of Commerce and Insurance will need to foster a regulatory environment that is supportive of expeditious market start-up activities, including COA approval, Medicaid contract execution, approval of plan document/policies, etc.

Coventry must weigh how it will be evaluated in comparison to health plans that are currently established and based in Tennessee. For instance, we encourage the Bureau to allow RFP response to increase provider Letters of Intent (LOI) versus executed contracts to demonstrate network adequacy. Executed contracts would be required within 60 days of receipt of RFP award status. Additionally, we encourage the Bureau to allow RFP respondents to submit proof of COA application, rather than require that a COA is approved by the RFP response due date.

The State of Tennessee can award MCO contracts in April 2006 and evaluate the contractor's progress in August 2006. If the contractor does not have an adequate delivery system, then the MCO should not be allowed to participate in the program for the October 2006 effective date. If this approach is utilized, then the proposed dates are feasible.

It is possible that some Tennessee Medicaid providers will be tentative regarding contracting with MCOs in the wake of recent MCO financial challenges. The Bureau may have to develop and or reinforce policies that encourage MCO contracting to ensure network adequacy.

2. Recommendations Regarding Timeframe

Core to the implementation of a new Medicaid program in any state is a well-timed approach. This well-timed approach will help to support the changes envisioned by the State of Tennessee, by ensuring all necessary program components are in place to meet cost and quality goals. We recommend that the RFP release date be postponed to April 1, 2006. This adjustment will enable the Bureau to fully review the RFI responses and to capitalize on any viable suggestions for inclusion into the RFP and/or program design. This proposal positions the Bureau to award contracts by July 1, 2006,

optimizing the capacity to fully implement the program by January 1, 2007. Readiness review could be conducted by October 2006.

The later implementation date will enable the state to study recommendations further, as well as better ascertain sundry support systems necessary to support this new model (i.e. enrollment broker or any direct TennCare information management interfaces not currently in use). At a minimum, Coventry will prepare to meet the proposed implementation timelines. However, Coventry's optimal implementation plan has been described in the preceding passage.

Overall Recommendations

Enrollment/Disenrollment Policies

Many state Medicaid agencies are using the auto assignment process as an incentive to encourage health plan quality/administrative performance. The auto assignment algorithm is designed to provide higher enrollment to plans that exceed the standards. This is commonly accomplished through the establishment of mutually agreed upon key quality/administrative benchmarks and reviewing plan performance against them. This is considered a powerful financial incentive to MCOs and has worked with varying degrees of success around the country. Key to the success of this incentive program is inclusion of benchmarks that allow a health plan to demonstrate performance improvement during the course of a year, versus employing standards with annual performance improvement opportunities, e.g., annual HEDIS reports.

Following the execution of new contracts, it is not uncommon for a state to establish the initial auto assignment algorithm based on such factors as MCO RFP scores and open provider capacity. Another option, for consideration of the Middle Tennessee re-launch, is to equally distribute auto assignment enrollment among the selected plans until specific quality/ administrative criteria can be developed.

Enrollment Broker

Many Medicaid agencies utilize enrollment brokers to manage the beneficiary education, outreach and enrollment functions. Should the Bureau decide to use an enrollment broker, it is important that the agreement include performance standards. These standards should include a specific set of reports to be made available to the health plans in some predetermined timeframe. Additionally, it is important to plan for adequate Management Information Systems (MIS) testing between the MCOs, broker and the state regarding transactional components such as enrollment files and beneficiary reports.

Enrollment Administration

All member eligibility, demographic and enrollment updates should be automated and provided to the health plans weekly.

It is important that the RFP and TennCare policies clearly define the health plan enrollment process. We recommend the administration of an enrollment lock-in, perhaps requiring a review of applicable waiver provisions. It is recommended that the lock-in be established for 12 months, following the 90 day 'trial period' per federal provisions. We further recommend the conduct of an annual open enrollment period, consistent with federal provisions. The open enrollment would begin 90 days prior to the effective date of the new managed care contracts. This will allow for predictability of membership and add to the effectiveness of disease management programs. In addition, members should be prospectively re-enrolled in the health plan if they lose and regain eligibility within 90 days. Any services rendered while the member is ineligible will be billed to fee-for-service.

We also strongly encourage minimal retro-enrollment activity. Retroactive enrollment should be restricted to newborns, whose mothers were active with the health plan at the time of birth. In

general, retro-enrollment wreaks havoc with management/cost of member care, especially when members have sought services outside the health plan's network. High levels of out of network payments for health plans could conflict with licensure standards regarding out of network payment restrictions. We encourage the Bureau to process health plan reenrollment, due to temporary loss of eligibility, changes in eligibility category, etc., on a prospective basis.

As the Bureau is intending to include the ABAD population in the Middle Tennessee roll out, there should be a mechanism in place to account for changes in beneficiary eligibility status and there concurrent rate adjustments. For example, when a TANF-eligible member subsequently becomes eligible under ABAD, there should be no need for disenrolling the member from the health plan. However, the new rate adjustment should be paid to the health plan retroactive to the month of ABAD qualification. This promotes continuity of care and prompt payment of actuarially sound rates to health plans.

The RFP should include definitive disenrollment standards for health plan members driven by the following circumstances:

- Identification of a high-risk newborn enrollment coordination process that directs the enrollment of these babies into the SSI program beginning the first day of the birth month until such time that the SSI population is included in the managed care program.

- Retroactive disenrollments, if accompanied by capitation recoveries, will need to include a clause that allows health plans to recover capitation from all providers and settle with the Bureau for any outstanding payments not recovered.

Plan-initiated disenrollment requests, should include circumstances where it is not feasible for the plan or provider to continue a relationship, e.g., suspected fraud/abuse by the member; violent or threatening behavior by the member, member's continued failure to follow prescribed treatment plans, etc.

Rate Setting

Competitive Bid versus State Established Rates

Coventry recommends that the Bureau consider establishing rates versus having them included in the competitive bid process. The competitive bid process tends to be cumbersome for both states and MCOs. If the rates are established and shared as part of the RFP process, the interested parties are then able to assess the rates and determine if they are willing to enter the marketplace. Instead, the RFP process should focus on quality, ability to deliver care, delivery system, experience, accreditation, and other factors that are a priority to the State and other stakeholders. It is important that the State rate development process include all costs and complies with actuarially sound methodologies, in accordance with the CMS requirements.

Disproportionate Share Hospital Payments

The Bureau's policy for financing DSH share dollars is of tantamount importance to health plans and hospitals alike. Inclusion or exclusion of DSH share payments in the health plan rates is a key consideration in the calculation of actuarially sound rates. Additionally, consideration should be given to the mechanism for distribution of DSH payments. A method based on

inpatient days will conflict with the health plan medical management goals. An approach based on a per admission proposal is more managed care friendly.

Maternity Case Rates (MCR)

Maternity care is a significant part of the Medicaid program nationally. Some beneficiaries are enrolled into MCOs in their second and third trimesters. The development of a feasible Maternity Case Rate payment structure helps offset the high cost of maternity services under these less than perfect circumstances for the MCOs, physicians and hospitals. The Bureau should compensate health plans for maternity on a case rate basis if the member has not been continuously enrolled in the plan for six months. In some states, the MCR aggregate payment is paid to health plans upon notification of a delivery. The rate is calculated based on facilities charges, delivery costs, and prenatal/postnatal physician services.

Rate History

The following represents information that should made available as part of the RFP.

- A data book and the corresponding rates. The corresponding trends, summaries, member months, total dollars, units, utilization per 1000 members, cost per unit and PMPM, and any other assumptions should be provided as well. The following are more detailed suggestions:
    1. Specifically for inpatient care data, days per 1000, admissions per 1000, and cost per day or admissions by level of service (i.e., med/surg, NICU levels, routine and c-section deliveries, etc.) should be included in the data book.
    2. Description of any data exclusions (i.e., data for ineligible members, particular types of service, etc.) inclusive of the reasons and the related assumptions.
    3. Trends should be detailed and specific to utilization and cost per unit.
    4. If the Bureau has included any projected savings from implementing a managed care program, these assumptions should be included as part of the data book.
    5. Any other assumptions or adjustments made to the base period data.
    6. Relative to the projected contract period, the data book should include member months, total dollars, units, utilization per 1000 members, cost per unit, PMPM, etc.
    7. The Bureau should provide the methodology used to develop the capitation rates payable to the health plans.
    8. The State's assumptions for administrative cost are a standard factor in rate setting. Therefore, it is recommended that this information and calculations be available as part of the data book.
    9. The data book should also include any assumptions that relate to any profit expectations/limitations and or risk contingency expectations that the Bureau may require as part of the contract. However, it should be mentioned that establishing minimum medical loss ratios could be a disincentive for managed care organization participation.

- All of the aforementioned data should be segmented by the proposed geographic regions, category of aid (i.e. SCHIP, TANF, Pregnant Women), rate cell (i.e., age and gender groupings), and category of service (i.e., inpatient, emergency room, outpatient surgery, lab services, radiology services, primary care physician services, specialist services, etc).

- If maternity case rate payments are developed, it is important that all of the preceding information be provided to document the fee development. If these payments are not part of the RFP, the details should be segmented by maternity and non-maternity services, with a description of how maternity services are defined.

- The RFP should include the history of Medicaid reimbursements (i.e., fee schedule and facility changes) and benefit changes made over the past 5 years. The financial impact of each change should also be included. Coupled with this data, the RFP should include any planned fee and benefit changes during the initial contract year. The RFP and the contract should include language that will allow the parties the opportunity to negotiate fee and benefit changes during the life of the contract.

Risk Adjustment

Capitation represents a reimbursement methodology based on how a population of people will utilize services. The methodology is flawed if there is high frequency of outliers. In Medicaid, these outliers are those cases deemed high-risk (i.e., sickle cell, HIV/AIDS cases, NICU babies, etc.). The RFP and MCO reimbursement policies should give special consideration for these cases and specifically cite the procedures for how these cases will be handled.

Quality Initiatives

UM / UR Standards Flexibility

The UM/UR standards established in the RFP/contract will follow specific Medicaid, and likely state, initiatives. Health plans should be allowed flexibility in determining which tool/protocol will be administered to satisfy the standards, i.e., InterQual, Milliman & Robertson.

Number of MCOs per Region

In regions with high concentrations of beneficiaries, Coventry recommends limiting the number of participating MCOs to no more than five. This rationale provides protection for the beneficiaries and the Bureau. If an existing plan exits the market, the Bureau will still have a sufficient number of other MCOs for transition/selection. Additionally, the existence of multiple MCOs contributes to the beneficiaries' choice options and may provide relief from the Grier consent decree regarding lock-ins, etc.

Medicaid Reimbursement Rates

The Bureau should consider establishing minimum contracting criteria. Medicaid rates should be established as the base level of payment regardless of par or non-par provider status. Assuming that the Bureau establishes the rates to be paid to the health plans, no one is advantaged or disadvantaged through the contracting process. The preferred policy to pay non-par providers at 90% of the Medicaid fee-for-service rates. This approach encourages provider participation with MCOs. Where no contract between the provider and MCOs exist, the hospital is only inclined to accept emergency admissions. If this policy is not adopted upon implementation, a common provider strategy will be to balance bill the beneficiary in an attempt

to obtain reimbursement at a level higher than Medicaid rates. This violates federal hold harmless provisions and artificially inflates the cost of care for the Medicaid program.

Moreover, we strongly encourage the Bureau to develop and publish a TennCare fee schedule to promote standardization in the Medicaid rate negotiation process.

For services rendered outside the state borders, we recommend the use of state reciprocity agreements if not currently in place.

The Bureau should consider an ER reimbursement approach that incorporates tier payments for non-emergent, observation, and true emergency visits. Other states utilize such ER case rate payment methodologies.

Provider Contracting

The RFP should identify mandated providers that will be required in the proposed MCO network, e.g., critical access hospitals (CAHs) or traditional community providers. If the Bureau does impose mandatory provider inclusion, a concurrent policy requiring these Medicaid providers to engage in reasonable contract negotiations with health plans should be developed.

The effectiveness of the contracted delivery systems is co-dependent upon contracting with providers currently servicing the Medicaid population. The RFP information should include sufficient information to determine the high volume providers, to enable bidders in the development of a delivery system composed of the providers currently servicing the Medicaid population. The information should also include the provider's name, address, specialty, languages spoken, etc.

Demographics of current beneficiaries should be made available, inclusive of languages spoken. This will allow the health plan to design culturally competent delivery systems.

Benefit Changes During Contract Period

The introduction of new benefits to the contract after the effective date should reflect a rate adjustment that is consistent with the cost of the new benefit and with the CMS actuarial soundness requirements. We propose that the Bureau provide actuarially sound rate adjustments at the time new benefits/services are introduced into the MCO contract. There is also the possibility of establishing a settlement process akin to the Federal Employees Health Benefit (FEHB) MCO contract process, where an annual reconciliation is conducted to adjust for mid-year coverage adjustments.

Mental Health and Other Services

The RFP should specifically identify the mental health services covered in the MCO contract and the requisite criteria, (i.e., provider type, diagnosis, procedures, etc.), that are the responsibility of the health plan.

Although the RFI indicates the State's intent to carve-out dental benefits, Coventry recommends that dental benefits be included in the MCO contract. The scope of dental services should be specifically defined, inclusive of procedure and diagnosis codes, provider types, benefit, frequency, etc.

Services Delivered Outside the MCO Contract

The RFP should specifically define excluded services. In cases where federal or state provisions require beneficiary access to medically necessary services outside the MCO (family planning, treatment of communicable diseases, etc.), the contract should specify that these services will be billed to the Bureau and are not the responsibility of the health plan.

Data Capture and Reporting

It is anticipated that the Bureau will have specific MCO data reporting standards. This requirement should be based on national reporting standards. Examples of these measures include, but are not limited to, EPSDT, well child visits, immunization rates, lead screening rates, timely claims payment, provider network access, etc.